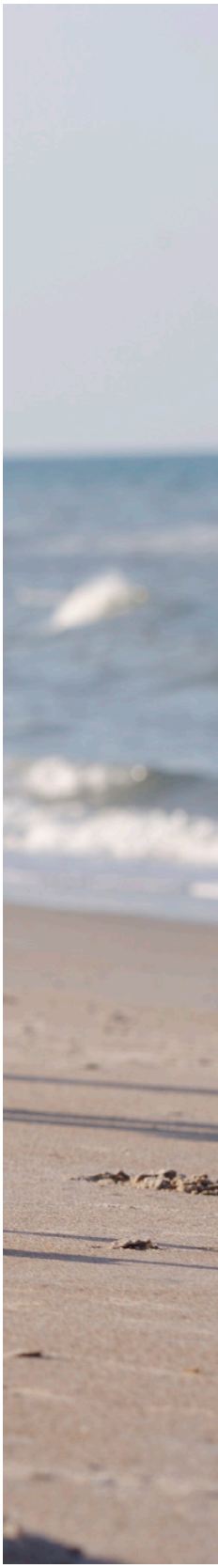
VISION PLAN



MERIDIAN HEALTH

United Healthcare Vision

A Partnership "TOTAL REWARDS" Program

UnitedHealthcare Vision

UnitedHealthcare Insurance Company

Certificate of Coverage

For

Meridian Health Systems

GROUP NUMBER: 754353

EFFECTIVE DATE: January 1, 2014

UnitedHealthcare Insurance Company

Group Vision Care Certificate of Coverage

Issued To:	Meridian Health Systems ("Enrolling Group")
Policy Number:	754353
Policy Effective Date:	January 1, 2014
Policy Anniversary Date:	July 1

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR *CERTIFICATE* CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide coverage for Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

Many words used in this *Certificate* and the attached *Table of Benefits* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Table of Benefits*.

When we use the words "we", "us", "our", and "the Company" in this *Certificate*, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your", we are referring to the people who are Covered Persons as the term is defined in *Section 1: Definitions*.

The Policy is delivered in and governed by the laws of the State of New Jersey.

Group Vision Care Certificate of Coverage

Table of Contents

Section 1: Definitions

Copayment - The charge that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

Covered Person - The Subscriber or an Enrolled Dependent but this term applies only while the person is enrolled under the Policy. Reference to "you" and "your" throughout this *Certificate* are references to Covered Persons.

Covered Contact Lens Selection - A selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Dependent - A Covered Person who is:

1. The Subscriber's legal spouse or civil union partner; or
2. An unmarried dependent child of the Subscriber or the Subscriber's spouse or civil union partner (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for coverage under the Policy, a Dependent must principally reside within the United States. The definition of "Dependent" is subject to the following conditions and limitations:

    A. The term "Dependent" will not include any unmarried dependent child 19 years of age or older, except as stated in the next paragraph, or as stated in *Section 3: Termination Provisions* section titled "*Extended Coverage for Handicapped Dependent Children*".

    B. The term "Dependent" will include an unmarried dependent child who is 19 years of age or older, but less than 23 years of age, if evidence satisfactory to the Company of the following conditions is furnished upon request:

        1. The child is not regularly employed on a full-time basis; and
        2. The child is a full-time student; and
        3. The child is primarily dependent upon the Subscriber for support and maintenance.

The Subscriber agrees to reimburse the Company for any Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom coverage for Services is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a 'Qualified Medical Child Support Order'.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.

Eligible Person - A person who meets all applicable eligibility requirements for vision care coverage.

Enrolled Dependent - A Dependent who is properly enrolled for coverage under the Policy.

Enrolling Group - The employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental, Investigational or Unproven Services - Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at

the time the Company makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the American Medical Association Drug Evalulations, or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - Services provided outside the U.S. and U.S. Territories.

Network Benefits - Coverage for Services provided by a Network Provider. Coverage for Services provided by a Non-Network provider are considered Network Benefits when such services are for Emergency Care.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Plan Year - A period of time beginning with the Policy Anniversary Date of any year and terminating exactly one year later. If the Policy Anniversary Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - The Group Vision Care Insurance Policy issued to the Enrolling Group.

Premium - The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Policy.

Service - Any covered benefit listed in *Section 4: Benefits* of this *Certificate*.

Subscriber - An Eligible Person who is properly enrolled for coverage under the Policy and is the person on whose behalf the Policy is issued to the Enrolling Group.

Total Disability or Totally Disabled - a Subscriber’s inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent’s inability to perform the normal activities of a person of like age and sex.

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

You may make coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, civil union, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next enrollment period.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event. Coverage for a newborn child is provided for 31 days and if payment of additional premium is required to provide coverage for the child, the Company must be furnished the required premium and be notified of the birth within 31 days after the birth in order to have the coverage continue beyond the 31 day period. Coverage for all other new Dependents is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Extended Coverage for Total Disability

A temporary extension of Coverage will be granted to a Covered Person who is Totally Disabled on the date the person's Coverage is terminated due to termination of the entire Policy. Benefits will be Covered until (a) the Total Disability ends or (b) 90 days from the date the Policy terminated, whichever is less. Such benefits are subject to the terms and conditions of the Policy.

Section 3: Termination Provisions

Termination of Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date the entire Policy is terminated for the reasons specified in the Policy. The Enrolling Group is responsible for notifying the Subscriber of the termination of the Policy.
2. The last day of the month during which the Covered Person ceases to be an Eligible Person.
3. The date requested in such notice when the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.
4. The date the Subscriber is retired or pensioned under the Enrolling Group's plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber:

5. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
6. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
7. The date specified by the Company that the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.
8. The date specified by the Company that all coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.
9. The date specified by the Company that your coverage will terminate because the Subscriber failed to pay a required Premium.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company or a Network Provider and the overpayment was paid to a Network Provider.

Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;

C. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and

D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's coverage under the Policy.

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the *Table of Benefits*. Your rights to benefits are subject to the terms, conditions, and exclusions of the Policy, including this *Certificate*, and any attached Amendments.

Obtaining Services

To find a Network Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Providers on the Internet at www.myuhcvision.com.

You also may obtain Services from a non Network Provider. However, the amount of coverage may be reduced.

Foreign Services

Foreign Services will be treated as Non-Network benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. The Company makes no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published in the Wall Street Journal on the date the claim is processed.

Section 5: Benefit Descriptions

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses; Subjective refraction - to determine lens power of corrective lenses;
9. Phorometry/Binocular testing - far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopic examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis;
17. Specific recommendations; and
18. Any other related services as designated by the Company.

Or in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses; Subjective refraction - to determine lens power of corrective lenses.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post-cataract surgery without intraocular lens;
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses; or
5. Any other condition the Company designates.

Section 6: General Provisions

Legal Actions

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. If a legal proceeding or action is not brought within 3 years of the expiration date, the right to bring action against the Company is forfeited.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an executive officer of the Company and the Enrolling Group. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Policy Charge.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of coverage under the Policy. A clerical error also does not create a right to benefits.

Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Workers' Compensation Not Affected

The coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Table of Benefits*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Table of Benefits*.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Table of Benefits* to the greatest extent legally permissible.

Covered Persons – Hold Harmless

The Network provider agrees that with respect to Covered Vision Services in no event, including, but not limited to: (1) non-payment by an organization with which the Company has contracted; (2) insolvency of the Company or any organization with which the Company has contracted; or (3) breach of any agreement between the Network provider and the Company; shall the Network Dentists, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons. This provision shall not prohibit collection of any Copayments or Deductibles in accordance with the terms of the Network provider’s agreement with the Company.

Section 7: Claims

Notice of Claim

Notice of claim as determined by us must be given to us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

When obtaining Services from a Network Provider, you will be required to pay a Copayment and any charges not covered by the Policy to your Provider. When obtaining Services from a Network Provider, you will not be required to submit a claim form.

When obtaining Services from a non-Network Provider, you will be required to pay all billed charges to your provider. You may then obtain reimbursement from us for the covered portion of Services.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name;
5. Patient date of birth; and
6. Any other information requested by the Company.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursements are payable no later than the 30th calendar day after the Company receives acceptable proof of loss.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Policy, you should contact UnitedHealthcare Vision Claims, PO Box 30978, Salt Lake City, UT 84130 or call toll-free at (800) 638-3120. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason you believe the claim should be paid.

Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following the receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 9: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

B. All or some of the payment made by the Company exceeded the benefits under the Policy; or

C. All or some of the payment was made in error.

Except in cases of fraudulent claims, we will make a written request for the reimbursement no later than 18 months after the date the first payment of the claim was made. The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

In seeking reimbursement for the overpayment from the health care provider, we will not collect or attempt to collect:

- The funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
- The funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal are exhausted; or
- A monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

We may collect the funds for reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal have been exhausted if we submit an explanation in writing to the provider in sufficient detail so that the provider can reconcile each covered person's bill.

If we determine that the overpayment to the health care provider is a result of fraud committed by the health care provider and we have conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, we may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

Section 10: Exclusions

The following Services and materials are excluded from coverage under the Policy:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Optional Lens Extras not listed in the *Table of Benefits*.
8. Missed appointment charges.
9. Applicable sales tax charged on Services.
10. Services that are not specifically covered by the Policy.
11. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: UnitedHealthcare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

The following Services will be covered in full, subject to a Copayment, when obtained from Network Providers.

When obtaining these Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Copayment at a Network Provider" in the chart below.

When obtaining these Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Routine Vision Examination or Refraction only in lieu of a complete exam	Once every 12 months	$10.00	Up to $40.00
Eyeglass Frames	Once every 12 months[1]	$20.00[2] (100% of the billed charge to a maximum of $130.00)	Up to $45.00
Eyeglass Lenses	Once every 12 months[1]		
• Single Vision		$20.00[2]	Up to $40.00
• Bifocal		$20.00[2]	Up to $60.00
• Trifocal		$20.00[2]	Up to $80.00
• Lenticular		$20.00[2]	Up to $80.00
Contact Lenses	Once every 12 months[1]	$20.00 (up to 6 boxes from the Covered Contact Lens Selection)[3]	Up to $105.00
• Necessary		$20.00	Up to $210.00

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
  - Standard Scratch-Resistant Coating

[1]You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

[2]If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[3]You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of $150.00. No Copayment will apply to non-selection Contact Lenses. Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for Non-selection Contact Lenses will be used.

UNITEDHEALTHCARE VISION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: April 14, 2003

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.myuhcvision.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care***. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers Compensation*** including disclosures required by state workers compensation laws of job-related injuries.

- ***Provide Information Regarding Decedents***. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information**. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, **www.myuhcvision.com**

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthcare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.

B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.

B. Reduction in the subscriber's hours of employment.

C. Death of the subscriber.

D. Divorce or legal separation of the subscriber.

E. Loss of eligibility by an enrolled dependent who is a child.

F. Entitlement of the subscriber to Medicare benefits.

G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator at the address stated in the ERISA Statement. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
   - the determination of the disability; or
   - the date of the qualifying event; or
   - the date the Qualified Beneficiary would lose coverage under the policy; and
   - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the subscriber's Medicare entitlement; or
   - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
- The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the policy for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.

H. The date the entire policy ends.

I. The date coverage would otherwise terminate under the policy.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information About Your Plan and Benefits

You are entitled to 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*.

You are entitled to 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 Plan Administrator may make a reasonable charge for the copies.

You are entitled to 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 the summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal

fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If 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*, *United States 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: Meridian Health Systems Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Meridian Health Systems
1430 Route 34
Neptune, NJ 07753
(732) 751-7568

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary:

UnitedHealthcare Insurance Company

Employer Identification Number (EIN): 22-3474145

IRS Plan Number: 501

Effective Date of Plan: The effective date of the Plan is January 1, 2014

Type of Plan: Vision care coverage plan

Name, business address, and business telephone number of Plan Administrator:

Meridian Health Systems
1430 Route 34
Neptune, NJ 07753
(732) 751-7568

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450

The Plan is administered on behalf of the Plan Administrator by UnitedHealthcare Insurance Company pursuant to the terms of the group Policy. UnitedHealthcare Insurance Company provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process: Plan Administrator

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan

Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records:

Plan year shall be a twelve month period ending July 1.

Determinations of Qualified Medical Child Support Orders. The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

SUMMARY PLAN DESCRIPTION SUPPLEMENT

Meridian Health Vision Plan

The certificate entitled "UnitedHealthcare Vision" (the "Certificate") describes the group vision insurance benefit that Meridian Health sponsors. The benefit as set forth in the Certificate makes up the insured vision component program (the "Plan") described in this Summary Plan Description Supplement ("Supplement"). The Plan is offered under the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan"), sponsored by Meridian Health.

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

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

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

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

Basic Plan Information

Type of Administration	Insurer administration – Benefits are provided and administered under an insurance contract with UnitedHealthcare Insurance Company
Plan Name	Meridian Health Vision Plan, 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 732-751-3553
Named Fiduciary	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753 732-751-3553
Agent for Service of Legal Process	Meridian Health Attn: General Counsel 1350 Campus Parkway Neptune, New Jersey 07753

Claims Administrator	UnitedHealthcare Insurance Company Claims Department P.O. Box 30978 Salt Lake City, UT 84130 800-638-3120
Plan Funding	The Plan is fully insured by UnitedHealthcare Insurance Company. Premiums are paid by Meridian Health and Plan participants.

Eligibility

Team Members

A person is eligible for team member coverage under the Plan (i.e., he or she is an Eligible Person) if he or she meets the following requirements:

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

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

Team members become eligible for coverage on:

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

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

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

- Part-time team members at Meridian Nursing & Rehabilitation Ocean Grove;
- Part-time team members at Wall Subacute;
- Meridian Health Resources physicians who are eligible for vision 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.

Enrollment

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.

1. *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.

2. *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 or if an applicable mid-year change event occurs and the employee elects coverage in a timely fashion as described in *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.

3. *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 *Change Events*).

   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.

Change Events

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

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

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

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

- Coverage under the Plan is significantly reduced or ends (if the significant reduction results in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, or if no similar option is available, drop coverage; if the significant reduction does not result in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, but you may not drop coverage completely);
- The cost of a benefit option significantly increases (you may elect to pay the increased cost for your current option, select a new benefit option, or revoke your coverage if there is no similar option);

- The cost of a benefit option significantly decreases (you may select that option);
- A similar benefit option is added, significantly improved or eliminated, and you are eligible to elect the new or improved option; or
- There are significant changes under your spouse's or civil union 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 or civil union 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.

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.

Continuation of Coverage

In addition to COBRA continuation coverage (discussed in *Continuation Coverage under Federal Law (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 Certificate and the Employer's employment policies and procedures, temporarily continue Plan coverage in accordance with such Certificate and 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 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave that is a qualifying leave under 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 his or her 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 Meridian HR Support Services Team.

Claims and Appeals Procedures

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

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

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

Urgent care claims (adverse or not) will be decided as soon as possible, but in no event later than 72 hours from receipt of the claim. If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 24 hours of receipt of the claim of the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by the Claims Administrator, the claim will be decided within 48 hours of the earlier of:

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

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

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

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

Notice of Adverse Benefit Determinations

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

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

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

Your Right to Appeal a Claim

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

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

If you wish to appeal an adverse determination, you have 180 days from the time you are notified to request a review. Problems as to claims between you and the Plan should generally be dealt with through the post-service appeal procedures listed below. If you have an urgent or pre-service appeal, refer to the appeals sections below for more detailed information on the types of appeals and the process for requesting a review.

Appeal of an Adverse Benefit Determination

If you wish to appeal in writing an adverse benefit determination decision, you may submit a claim appeal. The Claims Administrator or a representative of the Claims Administrator will consult with a vision 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 vision or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether the advice was relied on to make the initial decision. The Plan representative will review your appeal, make a determination on that appeal and communicate its decision to you or your representative as described below:

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

Notification of Benefit Determination on Appeal

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

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

Exhaustion Requirement

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

Administrative (Non-Benefit) Appeals

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

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

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

Disability Claims and Appeals

The claims procedure of the Plan shall be administered in accordance with the claims procedure regulations of the Department of Labor. Accordingly, determinations of whether Plan provisions that apply to a team member or Dependent who is disabled are applicable to such individual shall be made in accordance with the Department of Labor's claims procedure regulations applicable to claims for disability benefits, to the extent such regulations so require.

Continuation Coverage under Federal Law (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 vision 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 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).

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.

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.

<u>If You Have Questions</u>

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

Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator

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

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

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

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

Duties and Authority of the Plan Administrator

1. To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.
2. To make decisions and determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.
3. To determine the rights, eligibility, and benefits of Plan participants and beneficiaries, including deciding disputes which may arise relative to a Plan participant's rights. Benefits under this Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.
4. To describe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Amending and Terminating the Plan

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

APPENDIX A
LIST OF PARTICIPATING EMPLOYERS

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