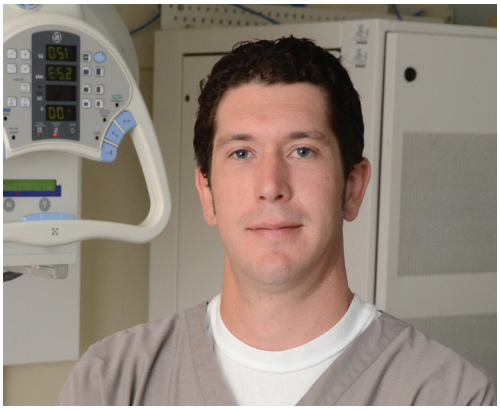
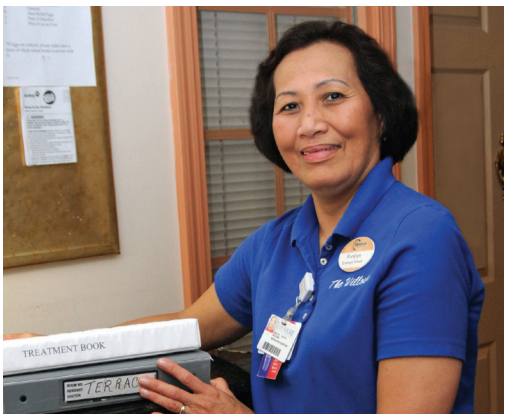
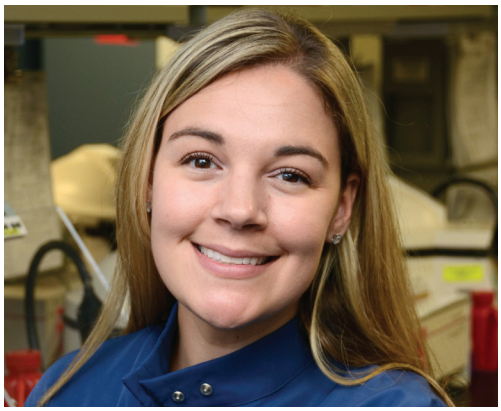
WELLNESS PROGRAM







Hackensack Meridian
HEALTH

Wellness Incentive Program

A Partnership "TOTAL REWARDS" Program

Meridian Health Systems, Inc

Wellness Incentive Program

2017 Summary Plan Description Supplement

Effective Date: **1.1.2017**

TABLE OF CONTENTS

Meridian Health System, Inc Wellness Incentive Program

INTRODUCTION

Meridian Health System provides its health plan participants and covered dependents with an opportunity to participate in a wellness incentive program (the Program). The Program includes financial impacts that impact employee health plan premium contributions if they qualify for certain pre-determined goals and criteria.

Bravo Wellness, LLC is the contracted service provider and is referred to as the Claims Administrator for the Program for purposes of this document.

HOW THE PROGRAM WORKS

By meeting various requirements or completing appropriate alternative standards under the Program, participants can qualify for a lower payroll deduction for their medical plan than the payroll deduction applied to a non-participant. Program participants may also be given opportunities to access health improvement resources and benefits designed to improve their overall health status. The Program requires an annual health screening. The screenings are generally offered on-site and are provided at no cost to eligible employees. Individual test results are not shared with the employer and are limited to entities that are permitted to receive Protected Health Information (PHI).

Generally, the value of the incentives earned is determined by the results of the health screening conducted. However, participants may be eligible to qualify for the full incentive upon completion of an alternative program. An annual calculation is performed in order to determine the maximum amount of outcomes-based incentive available to participants by law. If the amount available under the program exceeds the annual maximum permitted, the financial impact will be adjusted to the maximum permitted based upon your participation in the program.

Earn Points by Achieving Healthy & Reasonable Goals[1]

- ☐ Register, Complete Screening & Health Risk Assessment (Team members $5.00 per pay/Spouses $10.00 per pay) All three must be completed to earn the incentive
- ☐ Body Mass Index ≤ 25.5 (1 point)
  Waist measurement automatically corrects elevated body mass index (BMI) due to lean muscle mass, even if you fail the BMI goal. (Female ≤33 inches, Male ≤35 inches)
- ☐ Blood Pressure ≤ 120/80 (1 point)
- ☐ LDL Cholesterol ≤ 100 (1 Point)
- ☐ Glucose ≤ 100 (1 Point)
- ☐ Negative tobacco/nicotine result (1 Point)

[1] Refer to your Program Participant Guide and/or your Program Guide Plan Design for Alternative Options to qualify for the full reward.

PER PAY PERIOD PARTICIPATION INCENTIVE CREDIT		
Points Earned	TEAM MEMBER CREDIT	COVERED SPOUSE CREDIT
Participation (Register, complete HRA and biometric screening)	$5	$10
0 points	$0 + $5	
1 point	$0 +$5	
2 points	$5 + $5	
3 points	$10 +$5	
4 points	$15 + $5	
5 points	$20 + $5	

Participants should refer to program communications for additional details regarding the program. Helpful documents include the Program Participant Guide which contains the program Plan Design.

There is an appeal process for each point. The results of a health assessment do not necessarily preclude a participant from obtaining points under this Program. Refer to the Claims Administration section below.

The financial impacts shown above apply to the time period beginning on 01/01/2017 and ending on 12/31/2017.

If your denial is overturned any financial impact will be awarded to you as if you passed the goal initially. Your employer will retroact or prorate payment for the program impact period listed above.

If you are impacted by a leave of absence during the impact period, the financial impact of the Program will follow the provisions of your underlying group health plan. Refer to your group health plan document to determine the impact of leave on premiums and coverage.

If you are terminated from employment and rehired within the same plan year, the financial impact of the Program will follow the provisions of your underlying group health plan. Refer to your group health plan document to determine the impact of termination/rehire on premiums and coverage. You will not have to repeat the health screening for the Program if you previously completed a health screening for the same Program year.

If you change coverage tiers mid-year (e.g. a "qualifying event"), you will not have to repeat your health screening for the Program for the remainder of the Program year, however, if a dependent (e.g. a newly covered spouse) becomes eligible and had not previously completed a health screening for the Program year, the dependent will be offered an opportunity to participate in the Program.

COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

The Program will restrict the use and disclosure of protected health information (PHI) received and/or maintained in connection with the wellness incentive Program in accordance with the provisions of the medical plan SPD describing the compliance requirements under HIPAA.

PROGRAM ADMINISTRATOR'S RIGHT TO CONSTRUE AND INTERPRET PROGRAM

In deciding an appeal under these Procedures (Claim determination), the Program documents confer upon the Plan Administrator the discretion and authority to construe and interpret the terms of the Program and determine eligibility for benefits. This discretion shall also apply to the wellness vendor that decides claims on behalf of the Program Administrator.

CLAIMS ADMINISTRATION

You must achieve the stated goals and/or complete the actions required under the Program within the times and in accordance with the rules stated in the Program to qualify for the incentives. If you fail to do so, your incentives will be denied. However, you have the right to appeal that denial.

Initial Claim Decision

Following the deadline for performing the actions required under your wellness program, the Claims Administrator will notify you within 90 days of the end of the results gathering window if your incentives have been denied through your Results Letter. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Claims Administrator will send you a written notice that includes:

- The reason(s) for the denial;
- References to the specific Program requirement that was not achieved;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any; and
- A description of the Program's appeal procedures and the time limits applicable to the appeal process

Appealing the Failure of Program Goal(s) If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Claims Administrator after your receipt of denial of your claim. You may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

You can dispute the screening results and provide information from your physician certifying corrected results (must include lab report if applicable). Appeals must be provided within the 'appeals and alternative deadline' timeframe noted in the Participant Result's Letter (generally 30 days).

The results of a health assessment do not necessarily preclude you from obtaining points under this Program. You will be provided with an alternative method to qualify for the full value available for health contingent categories in

the Program through alternative means. Alternative means to qualify may be automatically applied to all Participants who have made improvement since a previous health assessment or made available to Participants upon request. Details and required timeframes to request alternatives are included in the Participant communications.

If a Participant can demonstrate that achieving the stated goal or the alternative goal provided is unreasonably difficult to achieve due to a medical condition or inadvisable to attempt due to a medical condition they must provide supporting documentation from their physician within the 'appeals and alternative deadline' timeframe noted in the Participant result communication (generally 30 days). Participants who cannot achieve the original goal or the alternative goal provided because of a medical issue will be given a waiver or a different option to qualify. The other option will be determined on a case by case basis by the Claims Administrator, the participant and your physician. Participants qualifying for the alternative award will earn the full incentive available and such incentives will be applied retroactively if applicable.

Claims Administrator's review will take into account all comments, documents, records and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Claims Administrator will notify you in writing of the extension within 60 days of receiving your appeal. Claims Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- References to the specific Program requirement that was not achieved;
- A statement that you have the right to request access to and copies of all relevant documents free of charge; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.
- Each level of appeal will be independent from the previous level (in other words, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not make the appeal determination).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim.
- If a claim involves medical judgment, the Claims Administrator will consult with your personal physician and follow their instructions
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Step 1: Notice of denial is received from the Claims Administrator. If your claim is denied, you will receive written notice from Claims Administrator that your claim is denied within 30 days of the deadline for completing all actions necessary to obtain the wellness incentive under the Program. Claims Administrator may request an extension of time in which to review your claim for reasons beyond Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information. The time period during which Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review your notice of denial carefully. Once you have received your notice from Claims Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Program or incentive program provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Program's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your final appeal and a description of the external review process and how to initiate the review process; and
- A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
- If the denial is based on a medical necessity, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

Step 3: If you disagree with the decision, file a second appeal with the Claims Administrator. If you do not agree with Claims Administrator's decision and you wish to appeal, you must file a written appeal with Claims Administrator within 180 days of receipt of denial notice referenced in Step 1. You should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 4: You receive a notice of the appeal from the Claims Administrator. If your appeal is denied, Claims Administrator will notify you within 60 days. The notice will contain the same type of information that was referenced in Step 2 above, including your right to bring a civil action following a denial of your appeal.

External Review Process for Cost-Sharing Incentive Claims (Not Applicable to Premium Adjustment Incentives)

External review is available for claims involving medical judgment or rescissions after you have exhausted internal review procedures. If you choose to request an external review, you must submit your request within four months after you receive a final decision from Claims Administrator under the mandatory appeal process described earlier. Claims Administrator will send your claim to the independent review organization contracted by your health plan. The independent review organization will then refer your case for review by a neutral, independent, board-certified physician with appropriate expertise in the area in question.

The independent review organization will make its determination on your claim within 45 days after your request and all necessary information has been submitted. Once the review is complete, the independent review organization will send the final determination letter directly to you. Claims Administrator will abide by the decision of the external review organization.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT ("COBRA")

The wellness incentive Program will be provided at your own cost to each qualified beneficiary who elects to continue medical coverage pursuant to COBRA under the terms set forth in the medical plan SPD to which this supplement applies (the "Medical Plan SPD").

AMENDMENT AND TERMINATION

The Plan Sponsor reserves the sole discretionary right to modify, amend or terminate the wellness incentive Program at any time and from time to time, retroactively or prospectively. You will be notified if the wellness incentive Program is amended or terminated.

RECOVERY OF INCENTIVES PROVIDED BY MISTAKE

Your incentives may be adjusted or you may be required to repay any amounts obtained under the wellness incentive Program by a mistake of fact or law. If you do not return benefits paid under the Program by a mistake of fact or law, the Plan may offset your future benefits up to the amount you owe to the Plan.

FUNDING

The wellness incentive Program is self-funded by the Plan sponsor, even if the medical coverage is fully-insured, and benefits are provided from the Plan sponsor's general assets.

WELLNESS PROGRAM IS PART OF THE PLAN

The wellness incentive Program is offered as a benefit under the Plan. See the Medical Plan SPD for a list of the plan sponsor, plan administrator and other important information.

STATEMENT OF ERISA RIGHTS

All individuals eligible to participate in the Program, including the wellness incentive Program, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as set forth in the Statement of ERISA Rights section of the Medical Plan SPD.