MERIDIAN HEALTH

Meridian Health Cafeteria Program

(Including Flexible Spending Accounts and Health Savings Account)

A Partnership "TOTAL REWARDS" Program

SUMMARY OF THE

MERIDIAN HEALTH CAFETERIA PROGRAM

January 1, 2014

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SECTION 1: GENERAL INFORMATION

The purpose of the Meridian Cafeteria Program (the "Plan") is to provide a vehicle for you to make pre-tax and after-tax contributions for certain health and welfare benefits and out-of-pocket dependent care and health expenses. The purpose of this Summary is to describe the important provisions of the Plan, including the pre-tax premium payment component (the "Premium Payment Component"), Health Savings Account ("HSA"), Health Care Flexible Spending Account (the "Health Care FSA"), and Dependent Care Flexible Spending Account (the "Dependent Care FSA" and together with the Health Care FSA, the "FSAs"). The Plan (except for the HSA) is sponsored by Meridian Health (the "Employer") for the benefit of eligible team members of the Employer and its affiliates, and is a component plan of the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan").

With respect to the Health Care FSA, this Summary constitutes the "summary plan description" ("SPD") required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). There are separate SPDs for the health and welfare benefit options available under the Welfare Benefit Plan. If you need a copy of a SPD for one of the welfare benefits, please contact the HR Support Services Team at HumanResourcesBenefits@meridianhealth.com.

The Employer has selected WageWorks, the Claims Administrator, to assist in the administration of the FSAs and process claims for reimbursement under the terms of the Plan. If you have questions about your FSAs, you may contact WageWorks via the following:

Online: www.wageworks.com

Phone: 1-877-924-3967

Fax: 1-877-353-9236

This Summary describes the major provisions of the Plan as of January 1, 2014. We have tried to explain the Plan's provisions in everyday language, but you will come across phrases that have specific meanings within the context of the Plan. Please be sure to read this Summary carefully as it contains important information about Plan administration and facts about your rights under applicable law and the Plan. Because flexible spending accounts are subject to Internal Revenue Service ("IRS") regulations, it's important to read this Summary carefully so you can learn more about your Plan benefits—how they work and how they can save you money through tax savings. You should consult your own tax advisor before you decide to participate.

We have tried to ensure that the Summary accurately reflects the provisions of the Plan. The plan document for the Welfare Benefit Plan governs and includes additional details on how the Plan operates. If there is any discrepancy between this Summary and the Welfare Benefit Plan, the Welfare Benefit Plan documents govern. You may obtain a free copy of the Welfare Benefit Plan by writing to the HR Support Services Team.

The Summary describes the benefits under the Plan as currently in effect. This Summary is not a promise that benefits will not be changed or terminated during your employment, or after your employment while still covered by the Plan (including, but not limited to, changes in the amount you are required to pay for coverage).

Please also note that the Plan does not create an employment contract between you and the Employer, and does not give you any right, expressed or implied, of continued employment with the Employer.

SECTION 2: ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

You must meet the eligibility requirements established by the Employer before you can enroll and begin participating in the Plan.

Eligibility

Team Members

You are eligible for team member coverage under the Premium Payment Component with respect to a particular benefit under the Welfare Benefit Plan (i.e., medical, dental, vision, employee supplemental life, and supplemental long-term disability) as of the first day that you become eligible for such benefit, as determined under the SPD and/or enrollment materials for such benefit, and complete the applicable waiting period (as described in "Initial Enrollment" below).

You are eligible for team member coverage under the FSAs as of the first day that you meet all of the following requirements:

1. You are a full-time, active team member of the Employer (i.e., you are regularly scheduled to work at least 36 hours per week and are employed as an employee on the regular payroll of the Employer for that work) or are a part-time, active team member of the Employer (i.e., you are regularly scheduled to work at least 20, but less than 36 hours per week and are employed as an employee on the regular payroll of the Employer for that work); and
2. You complete the applicable waiting period (as described in "Initial Enrollment" below).

However, the following team members are not eligible to participate in the FSAs:

1. Part-time team members at Meridian Nursing & Rehabilitation ("MNR") at Ocean Grove;
2. Team members at Shore Care Nursing;
3. Team members at Quality Care Management;
4. Part-time team members at MNR Brick, except for certain grandfathered team members;
5. Part-time team members at MNR Shrewsbury, except for (i) certain grandfathered team members and (ii) team members covered by a collective bargaining agreement providing for coverage;
6. Per diem team members; and
7. Team members covered by a collective bargaining agreement, unless the terms of the collective bargaining agreement provide for eligibility under the FSAs.

Plan coverage is not automatic. You must timely enroll in the Plan to be covered as an active team member.

For purposes of eligibility for coverage under the Plan, full-time and part-time team members who are absent because of health conditions are treated as if they are actively at work, and leaves of absence that qualify under the Family and Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA") are treated as periods of active employment to the extent such treatment is required and applicable to the Employer under such laws. Notwithstanding the foregoing, a newly hired or newly eligible team member must report to work for the Employer in order for any coverage under the Plan to become effective.

Dependents

Your dependents cannot enroll in the Plan unless your dependent is also an eligible team member of the Employer or one of its affiliates. However, you may submit any eligible medical expenses you incur on their behalf for reimbursement from your Health Care FSA, as applicable (see Section 7 for more information). In addition, certain dependent care expenses are eligible for reimbursement from the Dependent Care FSA, as applicable (see Section 8 for more information). If you elect to cover your dependents for certain health and welfare benefits (e.g., medical,

dental or vision coverage) under the Welfare Benefit Plan, the premium you are required to pay for that coverage will be deducted or paid under the terms of this Plan. For more information about which dependents are eligible for coverage under the Welfare Benefit Plan, please refer to the relevant SPDs.

Special Note Regarding Tax Considerations

If you enroll an eligible dependent for medical, dental, or vision coverage under the Plan, please keep in mind that if the dependent is not an IRS tax dependent for health coverage purposes, the value of Employer-provided coverage for the dependent will be treated as taxable income to you, a concept known as imputed income. See the section below entitled "Tax Treatment of Dependent Health Coverage." In addition, if an eligible dependent is not an IRS tax dependent for health coverage purposes, you will not be able to pay for his or her medical, dental, or vision coverage on a pre-tax basis under the Plan. State tax treatment may vary.

Tax Treatment of Dependent Health Coverage

Typically, the value of a dependent's coverage under an employer-sponsored group health plan, such as under the medical, dental or vision coverage elected under this Plan, is not included in the employee's income for tax purposes. However, if a dependent does not meet very specific requirements specified in the Internal Revenue Code ("IRC"), then the employer must add the value of the dependent's health coverage to the employee's income for tax purposes. This additional income is often referred to as "imputed income."

A dependent's medical, dental, and vision coverage elected under the Plan will not result in imputed income if that dependent is your spouse or an IRS tax dependent for health coverage purposes. For purposes of the medical, dental, and vision plan coverage elected under the Plan, an "IRS tax dependent" for this purpose includes a child who has not attained the age of 27 as of the end of the taxable year. For these purposes, your child is an individual who is:

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

If an individual does not meet the above definition of child, he or she will still be your "tax dependent" for health coverage purposes under the Plan if he or she is a U.S. citizen or resident who is either a qualifying child or a qualifying relative, as modified for health coverage purposes, as described below.

A "qualifying child" is a person who:

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

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

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

For example, your domestic or civil union partner will be your tax dependent for health coverage purposes if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you, and lives with you for the entire calendar year as a member of your household. Even though a domestic or civil union partner is not a "relative" in the traditional sense, he or she may meet the definition of a qualifying relative and could thereby be your tax dependent for health coverage purposes. Your domestic or civil union partner's child typically will not be your IRS tax dependent unless your domestic or civil union partner is also your IRS tax dependent for health coverage purposes.

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

Enrollment and Participation

Initial Enrollment

You become eligible for coverage under the FSAs on the first day of the month following your first day of employment or, if later, initial eligibility (subject to the conditions listed above). Your enrollment in the premium payment option for medical, dental, vision, supplemental life insurance and supplemental long-term disability coverage will follow the timing set out in the SPDs for those benefits. You must complete your enrollment no later than 31 days after such date. If you do not enroll during this initial enrollment period, you may enroll during any subsequent annual enrollment period, which is a period of time designated by the Plan Administrator before the beginning of each Plan Year (calendar year), or if you experience a Change Event as described in Section 4.

You may enroll in the Plan through the Meridian Health Intranet or by visiting www.TeamMeridian.com. You can also call or email the HR Support Services Team at 732-751-3553 or HumanResourcesBenefits@meridianhealth.com.

You must complete the enrollment process as instructed by the Plan Administrator. After the enrollment deadline, you cannot make any new elections or changes unless you experience a Change Event (see Section 4).

Your initial contribution to the Plan should begin as soon as administratively possible after enrollment. Thereafter, your contributions will be deducted from future paychecks in equal increments throughout the remainder of the Plan Year, or as otherwise determined by the Plan Administrator.

Annual Enrollment

If you are eligible to participate in the Plan, the Plan Administrator will, before the start of each Plan Year, provide you with enrollment materials to make your elections for benefits for the upcoming year. These materials will include information about your share of the cost for each benefit available under the Welfare Benefit Plan.

You may choose to enroll in the Plan during annual enrollment. Once enrolled, your participation in the Plan will begin at the start of the new Plan Year (January 1st). The premiums that you are required to pay for health and welfare benefits under the Welfare Benefit Plan (e.g., medical, dental, vision, supplemental life insurance and supplemental long-term disability) and the amount you choose to contribute to your HSA and/or FSAs during the Plan Year will be deducted from your future paychecks starting with your first paycheck in the new Plan Year.

Except as otherwise required by the Plan Administrator, your health and welfare benefit elections under the Welfare Benefit Plan will roll over from Plan Year to Plan Year, which means you only need to make a new election for welfare benefits (other than the FSAs) during annual enrollment if you want to change your prior election (e.g., from PPO to Inner Circle, remove a dependent child, etc.). Your HSA election also rolls over from year to year, but you

should review your HSA election each year as contribution limits typically change from year to year. If you're currently participating in the FSAs and want to continue your participation for the following Plan Year, you must re-enroll during the annual enrollment period. Participation in the FSAs does not carry over automatically from year to year.

Plan Year

The Plan Year runs from January 1 through December 31.

When Participation Ends

Subject to your rights to continuation coverage, as outlined in Section 12, you will no longer be eligible for coverage under the Plan after the earliest of the following dates:

1. The date you terminate active employment with the Employer or your employment status changes, resulting in loss of eligibility (that is, you cease to be an eligible team member);
2. The last day of the calendar month for which any required contribution has been paid, if the contribution for the next period is not paid when due;
3. Upon a finding by the Plan Administrator that you attempted to defraud the Plan or intentionally misrepresented a material fact to the Plan (termination of coverage in such circumstances may take effect on a retroactive basis);
4. The date you effectively elect to cancel your coverage;
5. The date the Plan is amended, resulting in your loss of eligibility;
6. The date the Plan is terminated; or
7. The date you die.

Your ability to make pre-tax contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements. For information about obtaining distributions from your HSA at any time, including after termination of employment, contact Wells Fargo, the custodian of your HSA established and maintained outside of the Plan.

The tax benefits you receive by participating in the Plan depend on your personal circumstances and financial situation. Because your circumstances can change from year to year, it's important to re-evaluate your need to participate in the Plan during annual enrollment. You should consult your own tax advisor for additional assistance about the tax consequences of your participation in the Plan.

SECTION 3: HOW THE PLAN WORKS

Through convenient payroll reductions, you may make regular premium payments of your required contributions for health and welfare benefits coverage elected under the Welfare Benefit Plan and/or make regular deposits into your HSA and/or FSAs to pay for qualified healthcare and/or dependent care out-of-pocket expenses.

Your premium contributions for health and welfare benefits under the Welfare Benefit Plan are limited to the cost of the benefits you elect.

The cost of coverage for the following health and welfare benefits under the Welfare Benefit Plan may be paid for under this Plan: medical (including prescription drugs), dental, vision, employee supplemental life, and supplemental long-term disability. Generally, your required premiums for medical, dental, and vision coverage will be made on a pre-tax basis, except for the cost of coverage for individuals who do not qualify as your IRS tax dependents for health coverage purposes (in which case your premiums are made on an after-tax basis). See the section above entitled "Tax Treatment of Dependent Health Coverage" for more information. Your required

premiums for employee supplemental life and disability coverage will be made on an after-tax basis. Your contributions to your HSA and/or FSAs will always be made on a pre-tax basis (unless such contributions are being made to Health Care FSA under COBRA). When your contributions are made on a pre-tax basis, you avoid federal income and Social Security taxes, as well as applicable state taxes, on the amount you set aside. By electing certain benefits, you authorize the Employer to withhold from your paycheck the corresponding cost you are required to pay for the benefits you elected.

All FSA elections are made on a Plan Year basis and therefore, a new election is required each Plan Year. You decide how much to contribute to your FSAs based on how much you expect to spend on qualified expenses during the Plan Year. If you do not expect to have any qualified health or dependent care expenses in a Plan Year, you may not want to contribute anything to your FSAs.

For more information about the health and welfare benefit options available to you under the Welfare Benefit Plan, please refer to the relevant SPD. Additional information regarding coverage options will be provided to you during each annual enrollment period.

SECTION 4: CHANGE EVENTS

Except with respect to HSA contributions, which you may prospectively change, waive, or revoke at any time, your Plan elections will remain in effect until the end of the Plan Year for which they are made, and you will not be able to change your election until the next annual enrollment period. Outside of the annual enrollment period, you can only change your Plan elections if you have a "Change Event." Any election change on account of a Change Event must be consistent with that event. The Change Events recognized under the Plan include those set forth below.

Please note that the qualified Change Event rules described below do not apply to your optional life and long-term disability insurance elections. You may only change such elections during open enrollment, subject to any evidence of insurability requirements.

Special Enrollment

Under the Health Insurance Portability and Accountability Act ("HIPAA"), you are allowed to enroll yourself and your eligible dependents in the medical, dental, and vision benefits outside of the annual enrollment period when certain events occur. Special enrollment rights exist when:

- You acquire a new dependent due to marriage, entering into a civil union partnership, birth, adoption or placement for adoption;
- You declined coverage under the Employer's group health plan during a previous enrollment period because you were covered under another group health plan (or group health insurance), but you subsequently lose your other coverage for any of the following reasons:
    - You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
    - Employer contributions toward the other group health plan coverage terminate; or
    - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
        - As a result of legal separation, divorce, dissolution of civil union or domestic partnership, cessation of dependent status, death, termination or reduction in hours of employment;
        - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area;
        - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area, provided that no other benefit package is available to you; or
        - When a plan no longer offers any benefits to your class of similarly situated individuals.
- You or your dependent becomes:
    - ineligible for coverage under a Medicaid plan or a state children's health insurance program ("CHIP"), and as a result coverage is terminated; or

- eligible for a premium assistance subsidy for the Employer's group health plan under Medicaid or the state CHIP.

When your special enrollment right results from the fact that you acquire a new dependent through marriage, entering into a civil union partnership, birth, adoption or placement for adoption, you can enroll your new dependent in the Employer's medical, dental, or vision plans. In addition, if you are not already enrolled in the medical, dental, or vision plans, you can enroll yourself during the special enrollment period. If your spouse, civil union partner, or domestic partner is not already enrolled in the Employer's group health plan and you have special enrollment rights because you acquire a new dependent, you can enroll your spouse, civil union partner, or domestic partner during the special enrollment period. However, you cannot enroll any other dependents who were already eligible for benefits but not previously enrolled in the Employer's group health plan.

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 applicable health 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 a civil union partnership, or dissolve a civil union or domestic partnership;
- The number of your eligible dependents changes (such as when a child becomes your dependent through birth or adoption; a person's dependent status — as defined by the IRC — 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, other than with respect to the Health Care FSA, outside of the annual enrollment period if:

- Coverage under a benefit option 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;
- There are significant changes under your spouse's, civil union partner's, or domestic partner's plan due to a mid-year election change that satisfies the IRC regulations, or a change during an open enrollment period where your spouse's, civil union partner's, or domestic partner's plan has a different plan year or enrollment period than the Plan; or
- If your dependent care expenses significantly increase or decrease during a Plan Year (e.g., due to a change in dependent day care providers), you may make a corresponding Dependent Care FSA election change.

This rule does not apply to an increase or decrease in dependent care expenses if the dependent care provider is your relative.

Qualified Medical Child Support Order

Your election with respect to your group health plan benefits or Health Care FSA 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 QMCSO) 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, you will be notified if the order constitutes a 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 with respect to your group health plan coverage or your Health Care FSA 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 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 at www.TeamMeridian.com.

If you have a Qualified Change Event during the year and need to change your coverage outside of the annual enrollment period, you must do so within 31 days of the Qualified Change Event (or within 60 days in the case of a special enrollment right due to loss of eligibility for Medicaid or CHIP coverage or eligibility for a state premium assistance subsidy from a Medicaid plan or through CHIP). Otherwise, you are not eligible to make a coverage change before the next annual enrollment period, unless you or your eligible family member has another Qualified Change Event.

Your new election will be effective as of the first day of the month following the date on which such Plan election is received, provided such election is received by the Plan Administrator (or the representative of the Plan Administrator) within 31 days after the event, except as follows:

- A change election on account of the birth, adoption, or placement of adoption of a new dependent shall be retroactive to the effective date of the event; and
- In the case of an enrollment due to marriage, coverage shall commence on the first day of the month following the date of the marriage.

Adding Civil Union Partners and Domestic Partners. 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 or domestic partnership at any time during the prior 12 months (note that effective January 1, 2014, new Domestic Partners are not eligible under the Plan).

SECTION 5: HOW THE HEALTH SAVINGS ACCOUNT (HSA) WORKS

If you elect to participate in the Meridian High Deductible Health Plan option (the CDHPlan) under the Welfare Benefit Plan, you may enroll in a HSA that is established and maintained outside of the Plan with Wells Fargo, the HSA custodian, in accordance with IRC Section 223. Benefits provided under the HSA, which may include Employer contributions to the HSA and your ability to contribute to the HSA on a pre-tax salary reduction basis, are called "HSA Benefits." Eligibility for HSA Benefits requires that you be an HSA-eligible individual.

HSA Benefits in General

The purpose of the HSA Benefit is to help you save and pay for "qualified medical expenses," as defined under IRC Section 223, for you, your spouse, and any dependent (as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). The HSA is not an Employer-sponsored employee benefit plan—it is a custodial account that you open with Wells Fargo to be used primarily for reimbursement of eligible medical expenses. Consequently, Wells Fargo, not the Employer, will maintain your HSA. Please note that the Employer does not endorse Wells Fargo. The Employer's role is limited to allowing you to contribute to your HSA on a pre-tax salary-reduction basis and make certain Employer contributions to your HSA.

The Employer has no authority or control over the funds deposited in your HSA. Neither your HSA nor the HSA component of this Plan that allows you to contribute to your HSA on a pre-tax basis is subject to ERISA.

Eligible Individual for HSA Benefits

To participate in the HSA benefits, you must be an HSA-eligible individual. This means that you are eligible to contribute to an HSA under the requirements of IRC Section 223 and that you have elected to participate in qualifying high deductible health plan coverage (i.e., the Meridian High Deductible Health Plan) offered by the Employer and have not elected any disqualifying non-high deductible health plan coverage. (High deductible health plan means the Meridian High Deductible Health Plan option offered by the Employer that is intended to qualify as a high deductible health plan under IRC Section 223(c)(2).)

If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under IRC Section 223 to be eligible to contribute to an HSA. You are eligible to contribute to an HSA if you meet the following criteria:

- You are enrolled in the Meridian High Deductible Health Plan option;
- You are not enrolled in Medicare;
- You are not claimed as a dependent on someone else's tax return; and
- You are not covered by another health plan that is not a high deductible health plan. This includes coverage received through your spouse's medical plan, or participation in the Health Care FSA (other than the Specific Use FSA described below), including if your spouse participates in a full purpose health care flexible spending account.

Your spouse is not eligible to enroll in the Meridian High Deductible Health Plan if he or she is:

- covered by another health plan, unless it is a qualified high deductible health plan;
- claimed as a dependent on another person's tax return; or
- enrolled in Medicare.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). In order to elect HSA benefits under the Plan, you must establish and maintain an HSA outside of the Plan with Wells Fargo, the HSA custodian, and you must provide sufficient

identifying information about your HSA to facilitate the forwarding of your pre-tax salary reductions through the Employer's payroll system to Wells Fargo.

If you elect to participate in the Health Care FSA, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA), unless you use your Health Care FSA only to pay for eligible dental and vision expenses (referred to as a "Specific Use FSA"). If you decide to enroll in both, your dental and vision expenses will be automatically reimbursed through the Specific Use FSA and your eligible medical and prescription drug expenses will be automatically reimbursed from your HSA.

Note about Dependent Coverage under the HSA Plan Option
You should carefully consider whether you want to enroll in the HSA Plan option if you want to cover a dependent child who is not a qualifying child or qualifying relative as those terms are defined for health coverage purposes under the IRC. Although you may enroll such a dependent child in the HSA Plan option if he or she meets the Medical Plan eligibility requirements, you may be reimbursed from your HSA for medical expenses incurred on behalf of your child only if the child is a qualifying child or qualifying relative, as modified for health coverage purposes. This means that, depending on your specific circumstances, you could elect to enroll your child in the HSA Plan option for purposes of the high deductible health plan portion, but find that you are unable to be reimbursed from your HSA for medical expenses attributable to that child's treatment. For example, if you elect coverage under the HSA Plan for a dependent child who is over age 19 and is neither a full-time student nor totally and permanently disabled, you will not be able to use money in your HSA for the child's medical expenses, unless the child meets the requirements to be a qualifying relative as defined in the Section Tax Treatment of Dependent Health Coverage

Maximum HSA Benefits

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to the Meridian High Deductible Health Plan coverage option under the Welfare Benefit Plan (i.e., single or family) for the calendar year in which the contribution is made. ($3,300 for single and $6,550 for family are the statutory maximum amounts for 2014.) An additional catch-up contribution of $1,000 may be made if you are age 55 or older (you must certify your age to the Employer).

In addition, the maximum annual contribution will be:

- reduced by any matching or other Employer contribution made on your behalf; and
- pro-rated for the number of months in which you are an HSA-eligible individual (as described above).

Note that if you are an HSA-eligible individual for only part of the year but you meet all of the requirements under IRC Section 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits, but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of IRC Section 223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 20% penalty (exceptions apply in the event of death or disability).

Paying for HSA Benefits

When you complete the election form to participate in the HSA, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). Such contributions will be forwarded to Wells Fargo (or its designee) within a reasonable time after being withheld.

Employer HSA Contributions

The Employer may make a contribution to your HSA in addition to your salary reduction contributions. Each year, the Employer determines, in its sole discretion, and will communicate to you, the amount of the Employer contribution to your HSA. As described above, the Employer has no authority or control over the funds deposited in your HSA.

Changing Your HSA Contribution

You may increase, decrease, or revoke your HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements.

Taxation of HSA Benefits

As noted above, when you pay for benefits on a pre-tax basis, the Employer deducts the amount from your base pay before any deductions for federal income taxes, Social Security and Medicare (i.e. FICA) taxes, and, in most states, state income taxes. However, very different rules apply with respect to taxability of HSA Benefits than for other benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA see the communications materials provided by Wells Fargo and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Failure to Establish HSA

If you fail to timely establish your HSA with Wells Fargo, you will not be permitted to make pre-tax salary contributions to your HSA and you will not receive the Employer contribution to your HSA.

For Additional Information

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying high deductible health plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA custodial account agreement and other documentation associated with your HSA and provided to you by Wells Fargo. You may also want to review IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) and/or consult a tax advisor.

Note that this Summary does not describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA custodial documents provided by Wells Fargo.

SECTION 6: HOW THE FLEXIBLE SPENDING ACCOUNTS (FSAS) WORK

A FSA is an Employer-sponsored benefit program that allows team members to set aside money on a pre-tax basis to pay for a variety of eligible healthcare and dependent care expenses. The Plan offers two types of spending accounts—a Health Care FSA and a Dependent Care FSA. For specific information about each type of FSA, read Sections 7 through 8. Flexible spending accounts can help you save money by reducing your taxable income. As the money you contribute to your FSA is deducted from your paycheck, your taxable income is reduced—this means you'll pay less in taxes.

Here's a general, step-by-step overview of how participation in a FSA works:

1. **Enroll in a FSA.** You must complete the online enrollment process through the Meridian Intranet or www.TeamMeridian.com (see Section 2 for details). There is a separate election for both the Health Care FSA and the Dependent Care FSA.
2. **Incur eligible expenses.** As a participant in a FSA, you may request reimbursement for expenses you incur when you visit eligible healthcare providers and purchase eligible healthcare items or services (Health Care FSA), and/or you incur eligible dependent care expenses (Dependent Care FSA). If you enrolled in the Health Care FSA, you will receive a My Care Card (i.e., a debit card) and you may use your card to pay for certain eligible healthcare expenses at the time the expense is incurred (see Section 9 for details). For other eligible expenses, you must submit a claim for reimbursement (see Section 10). Remember to save your receipts, as you may be required to submit additional documentation later.
3. **Receive reimbursement from your FSA.** Once your claim has been processed, you'll receive notification from WageWorks regarding the status of your claim and if any follow-up documentation is needed.

You may elect to sign up for direct deposit by contacting WageWorks at 1-877-924-3967 or by visiting www.wageworks.com.

Additional Information You Should Know

The IRS requires you to forfeit any funds in your FSAs for which you did not incur eligible expenses by the end of the Plan Year for which you are enrolled.

You must file all claims for services incurred during a Plan Year with WageWorks no later than March 31 following the end of the Plan Year, or you will forfeit any remaining funds in your account. Claims must be submitted online, post-marked or faxed to WageWorks by the deadline, or they will be denied. You cannot receive reimbursement for expenses incurred before you became a participant in the FSA, or after you ceased to be a participant in the FSA.

With this "use it or lose it" rule, it is important that you carefully plan your contributions to your FSAs. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

You may not use money in your Health Care FSA to pay dependent care expenses or vice versa, and you may not transfer funds between your Health Care FSA and your Dependent Care FSA.

In accordance with the IRC, the Employer may use forfeited funds to pay Plan administrative costs, or as otherwise permitted by law.

You can enroll in both the Health Care and Dependent Care FSAs. However, you'll need to allocate your annual contributions for each account separately. You may enroll in the Specific Use Health Care FSA, but not the Health Care FSA (i.e., the General Use Health Care FSA) if you are enrolled in the HSA.

Visit the WageWorks website at www.wageworks.com for information about FSAs and the most up-to-date listing of eligible health care and dependent care expenses. For more information about what items are and are not health care expenses under the Health Care FSA, consult IRS Publication 502. For more information about what items are and are not deductible dependent care expenses under the Dependent Care FSA, consult IRS Publication 503. Please use these publications with caution though, as they are not meant to explain what is reimbursable under a FSA. If you have additional questions or need assistance, you can call a WageWorks service center representative at 1-877-924-3967

SECTION 7: HEALTH CARE FSA DETAILS

You may use your Health Care FSA to pay eligible health-related expenses for yourself, your spouse, and dependents regardless of the insurance coverage you have, whether through the Employer or another source. The Health Care FSA is for health care expenses that aren't covered by any medical, dental, or vision care plan offered by the Employer or any other source (e.g., other employer coverage, Medicare, etc.). You may not claim a tax deduction with respect to expenses which are submitted for reimbursement. (See "Tax Implications for Health Care FSAs" below.) For the current Plan Year, you may contribute a minimum of $130 and a maximum of $2,500 to your Health Care FSA. Note: this $2,500 limit applies per team member (e.g., if each spouse is eligible for the Health Care FSA under their employer-sponsored plans, then each may defer up to $2,500).

When you submit a Health Care FSA claim, you can be reimbursed for eligible expenses up to the maximum amount of contributions you have elected for the Plan Year—even if those contributions have not actually been credited to your account yet.

Specific Use Health Care FSA

As noted above, if you elect to contribute to the Health Care FSA, you cannot also elect HSA benefits in connection with your participation in the Meridian High Deductible Health Plan option under the Welfare Benefit Plan or otherwise make contributions to an HSA, unless you use the Specific Use Health Care FSA only to pay for eligible dental and vision expenses. If you decide to enroll in both, your dental and vision expenses will be automatically reimbursed through the Specific Use Health Care FSA and your eligible medical and prescription drug expenses will be automatically reimbursed from your HSA. The Specific Use Health Care FSA is subject to the same terms and conditions as apply to the Health Care FSA (as described in this Summary), except that reimbursable expenses under the Specific Use FSA are limited to eligible dental and vision expenses.

It is important to remember is that the Health Care FSA constitutes family coverage, because it is available to pay or reimburse the qualified medical expenses of you and your spouse and dependents. As a result, if you participate in the Health Care FSA (and not the Specific Use Health Care FSA), your spouse will not be an HSA-eligible individual. Likewise, the fact that your child's qualified medical expenses could be reimbursed by your Health Care FSA will prevent the child from being an HSA-eligible individual.

Dependent Eligibility

You can use your Health Care FSA to pay for eligible health care expenses for yourself and anyone who qualifies as your tax dependent for health coverage purposes. Under the Health Care FSA, the term "dependent," as defined by the Plan and IRS regulations, includes:

- *Your legal spouse* – For purposes of the Health Care FSA, your legal spouse is an individual to whom you are lawfully married under the laws of any domestic or foreign jurisdiction where you were married. The Plan Administrator requires a certified copy of a marriage certificate.

- *Your dependents* – For purposes of the Health Care FSA, your "dependents" include individuals who are tax dependents for health coverage purposes under the IRC. To be a tax dependent for health coverage purposes, your dependent must be a citizen or national of the United States, or a resident of the United States, Mexico or Canada. If the dependent is your natural-born child, stepchild, legally adopted child (including a child placed with you for adoption), or eligible foster child, he or she is a tax dependent for health coverage purposes through the end of the year in which he or she turns age 26.

If an individual does not meet the above definition of child, he or she will still be your "tax dependent" for health coverage purposes under the Plan if he or she is a U.S. citizen or resident who is either a qualifying child or a qualifying relative, as modified for health coverage purposes, as described below.

A “qualifying child” is a person who:

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

If a person does not meet the definition of a qualifying child, he or she could be your tax dependent for purposes of the Plan by meeting the requirements to be a qualifying relative. A “qualifying relative” generally is a person who:

- receives over one-half of his or her support from you for the calendar year;
- is either related to you (i.e., your child or grandchild, sibling or step-sibling, parent or step-parent, niece or nephew, aunt or uncle), or lives with you for the entire calendar year as a member of your household; and
- is not your Qualifying Child or any other taxpayer's Qualifying Child during the calendar year.

Note: WageWorks is not responsible for determining employee or dependent eligibility for participation in any FSA plan. For more information on eligibility issues, please contact the HR Support Services Team.

Reimbursable Health Care Expenses

You may receive reimbursements from your Health Care FSA for any expenses you incur for “medical care” as defined in IRC Section 213(d). Under IRC Section 213(d), “medical care” expenses include amounts paid for the diagnosis, cure, relief, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. But expenses you incur in connection with activities or items that are merely beneficial to your general health, such as health club dues or vitamins, are not directly related to specific medical care and are not reimbursable. Keep in mind that if you are covered under the Specific Use Health Care FSA, you may be reimbursed only for eligible dental and vision care expenses.

Only expenses that are not covered by medical, dental, or vision care plans and are incurred during the Plan Year are eligible for reimbursement. For a listing of common eligible expenses, visit the WageWorks website at www.wageworks.com. Please note that the listing is subject to change at any time. For more information about what items are and are not medical care expenses under the Health Care FSA, consult IRS Publication 502. Please use this publication with caution though, as it is not meant to explain what is reimbursable under a healthcare FSA.

Eligible Expenses

Here are some examples of expenses that may be eligible for reimbursement from your Health Care FSA:

- Deductibles, coinsurance, and copayments you pay under the Meridian Health Team Member Medical Benefit Plan (the “Medical Plan”) and the Meridian Health Team Member Dental Plan (the “Dental Plan”) or under your spouse’s health care plan(s);
- Charges that are not covered by the Medical Plan options, such as costs for routine physical exams or tests not reimbursed as eligible preventive care expenses under your Medical Plan option;
- Charges that are not covered by the Dental Plan, such as charges over the annual maximum or that exceed other plan maximum limits;
- Medical or dental charges that exceed reasonable and customary limits;
- Vision care expenses, including routine examinations, eyeglasses, contact lenses, and prescription sunglasses;

- Charges for medicines, which generally include (1) prescription drugs, (2) insulin, and (3) over-the-counter drugs and medicines that are prescribed by a physician or other lawful prescriber and are used to treat a medical condition;
- Diabetic supplies;
- Hearing loss expenses, including routine examinations and hearing aids;
- Weight-loss program expenses if prescribed by a physician for curing, mitigating, or treating a specific ailment;
- Smoking cessation programs;
- Expenses for breast pumps and supplies that assist lactation;
- Special equipment, design, and operating costs for a car used by a disabled person;
- Transportation expenses primarily for and essential to medical care, including fares for public transportation and actual out-of-pocket expenses;
- Charges for attendance at a special school for a person with a mental or physical handicap, provided certain conditions are met; and
- Tutoring by a licensed school or therapist for a child with a severe learning disorder.

Expenses That Cannot Be Reimbursed

Here are some examples of expenses that do not qualify for reimbursement from your Health Care FSA:

- Expenses reimbursed by any other health plan, including Medicare and Medicaid;
- Premiums for health care coverage (including medical coverage under automobile insurance), long-term care coverage, life or accident insurance policies, or any other types of coverage;
- Cosmetic surgery (whether surgical or dental, unless required to treat an illness, injury, or disfiguring disease);
- Funeral or burial expenses;
- Household and domestic help;
- Custodial care in an institution;
- Charges for over-the-counter drugs and medicines purchased without a prescription from a physician or other lawful prescriber (except insulin is an eligible expense);
- Any expenses related to an illegal operation or treatment;
- Health club dues, YMCA and YWCA dues to paid to improve one's general health or to relieve physical or mental discomfort not related to a particular medical condition;
- Social activities, such as dance lessons or classes, even when recommended by a physician to improve general health;
- Membership fees and costs associated with weight-loss programs for general health and well-being;
- Bottled water;
- Maternity clothes and diapers;
- Cosmetics, toothpaste, and other toiletries;
- Uniforms;
- Vacation or travel taken for general health reasons or travel to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Transportation expenses to and from work (even though your physical condition may require special means of transportation); and
- Long term care expenses.

Note: Keep in mind that you can only be reimbursed for eligible expenses that were incurred while contributing to a Health Care FSA.

Tax Implications for Health Care FSAs

Under current federal tax law, expenses paid from your Health Care FSA would normally be deductible on your federal income tax return if they exceed 10% of your adjusted gross income. However, when you are reimbursed for these expenses from your Health Care FSA, you give up the opportunity to take a tax deduction for those same items. Therefore, when you consider whether or not to enroll in a Health Care FSA, you must decide whether you want to take the deduction or be reimbursed for those expenses from your Health Care FSA. Generally, if you don't itemize deductions, or if your health care expenses are less than 10% of your adjusted gross income, it will be better for you to be reimbursed for expenses from a Health Care FSA.

Keep in mind that these are only general guidelines. The amount you save in taxes when participating in the Health Care FSA depends on your personal situation. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor before deciding whether to use the Health Care FSA or to take a tax deduction for eligible medical expenses. The Employer cannot – by law – offer you advice on tax issues or your elections. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is available only from a qualified tax advisor.

Continuation Rights

If you lose Health Care FSA coverage due to termination from employment or an employment status change, you may be eligible to temporarily continue participation in your Health Care FSA (on an after-tax basis) through COBRA continuation coverage. See Section 12 for more details. If you qualify for health care coverage continuation through COBRA, you'll receive additional information from the HR Support Services Team about continuing to participate in your Health Care FSA.

SECTION 8: DEPENDENT CARE FSA DETAILS

The Dependent Care FSA covers eligible dependent care expenses so that you (or you and your spouse, if you're married) can work (or look for work) or your spouse can attend school full time. For the current Plan Year, you may contribute a minimum of $130 and a maximum of $5,000 per your household if you are married and filing a joint return or if you are single ($2,500 if you are married and you and your spouse file separate federal income tax returns) to your Dependent Care FSA.

Dependent Eligibility

You may use the Dependent Care FSA to pay for dependent care expenses, which are generally expenses incurred for the care of your qualifying dependents so that you, or if you are married, you and your spouse, can work (or look for work). These qualifying dependents must live with you and must depend on you for financial support. Your qualifying dependents are defined under IRC Section 21(b)(1) and may include:

- Your "qualifying child" who has not attained age 13 (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

- your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the IRC (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the IRC's definition).

If a child of divorced or separated parents resides with one or both parents for more than half the year and receives over half of his or her support from one or both parents, the child may be considered a qualifying individual only with respect to the child's custodial parent (as defined in IRC Section 152(e)(3)). This determination is made without regard to which parent claims the child as a dependent on his or her tax return. See the Plan Administrator for more information on which individuals will qualify as your qualifying dependents.

Your civil union partner or domestic partner, and his or her dependent children are not eligible for coverage in the Dependent Care FSA, unless they qualify as your dependents for federal tax law purposes, as described above. Under federal tax rules, FSAs cannot reimburse expenses incurred on behalf of a domestic or civil union partner or his or her children (except to the extent those children qualify as your dependents under federal tax law).

Note: WageWorks is not responsible for determining employee or dependent eligibility for participation in any FSA. For more information on eligibility issues, please contact the HR Support Services Team.

Maximum Annual Contribution

Generally, you may elect to contribute up to $5,000 per your household if you are married and filing a joint return or if you are single ($2,500 if you are married and you and your spouse file separate federal income tax returns) per calendar year to the Dependent Care FSA. However, Dependent Care FSA reimbursements cannot exceed your earned income for the year and, if you are married, cannot exceed your spouse's earned income for the year. For purposes of this rule, if your spouse is, for any month, a full-time student or incapable of self-care and has the same principal residence as you for more than half the year, your spouse will be deemed to have earned income of $250 per month, if you have one qualifying dependent, or $500 per month, if you have two or more qualifying dependents. Note: These limits are set under the IRC and apply to you and your spouse on a combined basis – so, for example, if both you and your spouse are eligible to set up this type of account (under the Plan or a plan maintained by another employer), your combined contributions to the accounts cannot exceed the applicable limits.

Highly compensated employees (as defined under IRC Section 414(q)) may be subject to federal tax law limits on the amount they can contribute to the Dependent Care FSA on a pre-tax basis each year. Federal tax law limits the extent to which highly compensated employees can make pre-tax contributions to a Dependent Care FSA, based on the extent to which other employees make pre-tax contributions to the Dependent Care FSA. If the contributions made by highly compensated employees exceed that limit for a calendar year, then some or all their contributions must be reported as taxable income for that year. You will be notified in writing if this limit affects you.

Reimbursable Dependent Day Care Expenses

To be eligible for reimbursement, your dependent care expenses must meet all of the following requirements:

- The expenses must be provided primarily for the well-being and protection of the dependent;
- The care/service must be necessary for you to work and, if you're married, for your spouse to work, look for work, or attend school full time (unless your spouse is disabled);
- If the services are provided in your home by a babysitter or companion, the dependent care provider is not your child who is under age 19 at the end of the year in which the expenses are incurred, your dependent, your spouse, or a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent);
- If the expense is for services provided outside your home, then the care must be for your child who is under age 13, or for an individual who is incapable of self-care and regularly spends at least eight hours a day in your household;

- If the expense is incurred at a facility that provides care for more than six nonresidents, then the facility must meet certain tax-identification requirements and comply with all applicable state and local laws; and

- The service for which reimbursement is being requested has been incurred in full.

Eligible Expenses

Examples of expenses eligible for reimbursement through the Dependent Care FSA may include:

- Nursery school tuition;
- Day care centers (including adult day care facilities);
- In-home day care providers; and
- Before- and after-school care (if not included with tuition).

Expenses That Cannot Be Reimbursed

Examples of expenses that are not eligible for reimbursement through the Dependent Care FSA include:

- Food and clothing;
- Entertainment;
- Education (for kindergarten or higher);
- Care provided by your child who is under age 19 at the end of the calendar year in which the expenses are incurred, an individual whom you could claim as your dependent on your federal income tax return, your spouse, or a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent);
- Overnight camps;
- Health care expenses;
- Full-time nursing home care;
- Expenses reimbursable under any other plan or program;
- Expenses for dependent care for non-work-related reasons or so that your spouse can perform volunteer work;
- Dependent care provided while you are away from work because of illness or leave of absence, except for short, temporary absences from work;
- Expenses you claim for the dependent care tax credit on your federal income tax return; and
- Transportation expenses, including chauffeur services, unless for transporting a qualifying dependent to or from a place where care is provided and is furnished by the dependent care provider.

For a complete listing of eligible expenses, visit the WageWorks website at www.wageworks.com. Please note that the listing is subject to change at any time. For more information about what items are and are not deductible dependent care expenses under the Dependent Care FSA, consult IRS Publication 503. Please use this publication with caution though, as it is not meant to explain what is reimbursable under a dependent care FSA.

If you are enrolled in the Dependent Care FSA, you can only be reimbursed up to the amount that is available in your account (based on current contributions). If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

Tax Implications for Dependent Care FSAs

You may not claim any other benefit for the amount of your pre-tax salary reductions under the Dependent Care FSA, although your dependent care expenses in excess of that amount may be eligible for the dependent care tax credit.

For example, if you elect $3,000 in the Dependent Care FSA and are reimbursed $3,000, but you have dependent care expenses totaling $5,000, then you could count the $2,000 excess when calculating the dependent care tax credit if you have two or more dependents.

Q. **Would it be better to include the Dependent Care FSA benefits in my income and claim the dependent care tax credit, instead of treating the reimbursements as tax free?**

A. For most individuals, participating in a dependent care spending account will produce the greater federal tax savings, but there are some for whom the opposite is true. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (for example, married, single, head of household, number of dependents, earned income, etc.), each person must determine his or her own tax position individually in order to make the decision. For more information on this subject, visit the IRS website at **www.irs.gov** or consult with your own tax advisor to determine what is best for your situation.

SECTION 9: THE FSA CARD PROGRAM

If you've chosen to participate in the Health Care FSA, you will receive a My Care Card (the "FSA Card") that you can use to pay for eligible health care expenses. As you use your prepaid FSA Card, eligible health care expenses will be deducted automatically from your account.

How the FSA Card Program Works

If you're eligible, you'll receive a package containing two FSA Cards issued in your name, activation instructions, and information explaining approved uses of the card.

The FSA Card remains active as long as your account is in good status, you continue to participate in the Health Care FSA, and you remain actively employed with the Employer or one of its affiliates. Your card will be cancelled upon termination of employment—inactive participants may not use the FSA Card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible dependents under the Plan, as applicable.
- Incurred expenses were for health care services or supplies purchased on or after the date your FSA took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible, as applicable.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

The FSA Card will work at health-related businesses that accept Visa. Health-related businesses include doctors, dentists, vision care facilities, and other locations that sell medical services/products only. The FSA Card automatically approves purchase of eligible items from your Health Care FSA at the point of purchase.

When using the FSA Card, you should select "credit" as an option, not "debit."

Important! Save your itemized receipts.

Because all FSA Card transactions must be verified as eligible expenses, you may be required to provide WageWorks with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, the name of the service provider, the name of the person receiving service, the name of the product or service, and any amount paid by other coverage).

When you use your FSA Card, some of the amounts you charge may be treated as conditional, pending substantiation, until you provide additional independent third-party information describing the goods or services, the date of the service or sale, and the amount of the transaction. If you do not substantiate your claim in a form that WageWorks finds satisfactory, WageWorks may take the following steps with respect to the unsubstantiated claims:

- *Deactivate Card*. WageWorks may deactivate your FSA Card. You may continue to request payments or reimbursements of eligible expenses from your Health Care FSA by submitting receipts for reimbursement. Your FSA Card will be reactivated when you substantiate your pending claims.
- *Request Repayment*. WageWorks may request that you repay the amount of the unsubstantiated claim(s) to the Health Care FSA.
- *Offset*. If an unsubstantiated amount remains outstanding, WageWorks may apply a claims substitution policy and reduce a later claim for a substantiated expense within the same coverage period by the amount of the improper payment.
- *Treat as other Business Indebtedness*. If amounts still remain unsubstantiated and outstanding, the Employer may treat the improper payment as it would treat any other business indebtedness and take the same steps it would take to collect an equivalent business debt.
- *Reclassify as Taxable Earnings*. The Employer may reclassify the amount of your unsubstantiated Health Care FSA claims as taxable earnings.

The FSA Card can remain active *as long as you maintain active status and/or are eligible for benefits*. As a reminder though, for any given Plan Year, you must use all of the money in your account(s) to pay for eligible expenses incurred during the Plan Year; you cannot rollover unused funds from year to year.

Note: To submit claims for a given Plan Year during the three-month run-out period immediately following such Plan Year (i.e., January 1 through March 31 of the following year), you must use the manual claim process. Transactions that are not automatically validated by the FSA Card will apply toward the new Plan Year balance until additional documentation is provided.

For more information on the FSA Card, please visit www.avantserve.com.

SECTION 10: CLAIMS FOR REIMBURSEMENT

As you incur eligible expenses during the Plan Year, you can submit claims to WageWorks for reimbursement. To do this, you must complete a claim form and include acceptable documentation of your eligible expenses when it's requested. Make sure to submit your claims incurred during the current Plan Year by the end of the run-out period (March 31 following the end of the Plan Year).

Submitting Your Claim to Your Spending Account

There are several ways to submit your claim for reimbursement.

FSA Card

When you use your FSA Card, your claim is automatically submitted for payment from your Health Care FSA expenses.

Online

WageWorks offers the convenience of submitting your claim form online. To get started, log on to the www.wageworks.com website. You'll then be asked to enter relevant claim information. Once you've entered the requested information, you'll be able to review your claim before you submit it. The final steps to submitting your claim are to print a copy, sign it, and fax or mail it to WageWorks with the required documentation of your expenses (such as itemized receipts) for processing.

Fax or Mail

If you don't have Internet access, you can obtain a paper claim form by calling WageWorks at 1-877-924-3967. Once you've completed and signed the claim form, you'll need to include itemized receipts or other required documentation of your expenses with your form when you fax or mail it to WageWorks for processing.

Where do I send my claim form?

Fax your claim to: 1-877-353-9236

Mail your claim to: WageWorks Claims Administrator
PO Box 14053
Lexington, KY 40512

Important: Whether you submit a claim through the website or by fax/mail, you must provide itemized receipts or other required documentation for products purchased or services rendered. If you don't provide supporting documentation, your claim won't be processed and you won't be reimbursed.

Supporting Documentation

You must provide proper supporting documentation so that your claim can be approved. This includes itemized receipts or other documentation.

For Health Care FSA Claims

An itemized receipt must include the following:

- Date of service;
- Name of service provider;
- Name of patient;
- Name of drug, product, or service; and
- Amount paid.

Handwritten receipts should include the service provider's signature. For prescription drugs, remember to submit the receipt that the pharmacist has attached to the prescription, not the cash register receipt. For faster processing, fax your signed and completed claim form and supporting documentation to WageWorks. Your claim will be processed as soon as possible.

If you've lost a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an explanation of benefits ("EOB"). If you don't provide the necessary information, your account may be suspended until your purchases are substantiated as eligible under the Health Care FSA. See the Section "Important! Save your itemized receipts," or visit the WageWorks website for more documentation requirements.

For over-the-counter medicine, you'll also need to submit a prescription from an authorized health care provider that includes:

- Name of patient;
- Date;
- Name and address of provider;
- Name of specific product prescribed;
- Dosage; and
- Provider's signature.

For Dependent Care FSA Claims

If you use a care provider or day care service, your receipt must contain the following:

- Dates of service;
- Name of service provider;
- Name of dependent receiving services; and
- Amount paid.

If Your Claim Is Denied

See the "Claims Processing" for more information about claims review and appeals procedures.

SECTION 11: CLAIMS PROCESSING

Administrative Claims

Administrative issues include questions you may have regarding eligibility; changes in status; special enrollment; termination of coverage; and QMCSOs. Administrative issues also include questions relating to the payroll deductions taken for pre-tax or after-tax benefits (such as a dispute about the amount of a deduction or the cost for the coverage elected). If you have a claim involving an administrative issue, the claim should be submitted to the Plan Administrator. Claims and appeals involving administrative issues will be reviewed by the Plan Administrator (or its delegate), and decided in a uniform and nondiscriminatory manner, as follows:

- The Plan Administrator will respond to your claim within 60 days after receipt.
- If the claim is denied (in whole or in part), you will be advised of the decision and informed of your right to appeal.
- You may appeal the denial by filing a written request with the Plan Administrator within 30 days after your receipt of the denial.
- If the claim denial is appealed, the Plan Administrator will render a decision within 60 days after receipt of the claim. If the Plan Administrator determines that an extension is necessary due to matters beyond its control, you will be notified within the initial 60-day period.
- If the Plan Administrator denies the claim (in whole or in part), you will receive written notice describing the reason for the denial. The Plan Administrator's decision is final and cannot be further appealed under the Plan.

Claims under Welfare Benefit Plan

If you file a claim under one of the benefits offered under the Welfare Benefit Plan (other than claims for Health Care FSA or Dependent Care FSA benefits) and that claim is denied, the claim review and appeal procedures of the specific benefit (e.g., medical, dental, vision, etc.) will govern. You must consult the procedures contained in the relevant SPD for more information.

Claims Processing for FSA Benefit Claims

In General

Generally, the responsibility for deciding claims for benefits under the FSAs rests with WageWorks, the Claims Administrator. The Plan Administrator has delegated to the Claims Administrator the discretionary authority to grant or deny benefits under the FSAs. Benefits under the FSAs will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Claims Review Procedures

If you (or your beneficiary or representative, in the case of your death) believe you are entitled to a benefit under the FSAs that has not been provided, or you disagree with any other action taken by the Claims Administrator, the FSAs provide appeals procedures in compliance with applicable law.

Claims under the Dependent Care FSA

The Claims Administrator will review all claims and either grant or deny them within 30 days. If special circumstances require more time, you will be notified during the initial 30 days regarding how much additional time is needed and why. If you do not hear from the Claims Administrator during the initial 30 days or any extension period, you may consider the claim denied. You will have 60 days to appeal any denied claims to the Claims Administrator. WageWorks will review appeals on a fair and nondiscriminatory basis and respond within 30 days.

Claims under the Health Care FSA

If you file a claim for reimbursement of health care expenses from the Health Care FSA and your claim is denied, you will be notified of the denial within 30 days after receipt of the claim. This period may be extended by up to 15 days if (1) the extension is necessary due to matters outside of the Claims Administrator's control, and (2) the Claims Administrator notifies you of the circumstances requiring the extension and the date a decision is expected. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15-day extension period will begin after you provide the information. Any notice you receive regarding an adverse decision on your claim will include the information described below under the heading "Notice of Adverse Decisions."

Notice of Adverse Decisions

If your claim for Health Care FSA benefits is denied, in whole or in part, you will be notified in writing or electronically, and the notice will include the following information:

- the specific reason or reasons for the denial of the claim;
- reference to the specific Plan provisions on which the denial is based;
- a description of any internal rule, guideline, protocol, or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);
- an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);
- a description of any additional material or information that you may need to provide with respect to the claim, with an explanation as to why the material or information is necessary; and
- an explanation of your right to appeal the claim denial under the Plan's review procedures and your right to bring a civil action in federal court following any further denial of your claim on review.

Appeals Procedures

If your claim for Health Care FSA benefits is denied, you will have 180 days from the date of the decision to appeal to the Claims Administrator for review of the denial. Generally, your request must be in writing and signed by you or your authorized representative.

You will be notified of the decision on your appeal within 60 days after the Claims Administrator receives your request for review.

The following provisions apply to your right of appeal:

- You will have the opportunity to submit written comments, documents, or other information relating to your claim.

- Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relating to your claim.

- The review will take into account all comments, documents, records, and other information you submit, whether or not presented or considered in the initial determination.

- No deference will be given to the initial determination.

- The review will be conducted by a person different from the person who made the initial determination and who is not the original decision maker's subordinate.

- If the decision was made on the grounds of a medical judgment, the Claims Administrator or its designee will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

- The Claims Administrator or its designee will provide you with the name of any medical or vocational expert who advised the Plan with respect to your claim.

You will be notified of the decision on your appeal, in writing or electronically. If your claim for review is denied, the notice will contain the following information:

- the specific reason or reasons for the decision;

- a reference to the specific Plan provision or provisions on which the denial is based;

- a statement disclosing any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination (or a statement that such information will be sent to you free of charge upon request);

- an explanation of any scientific or clinical judgment on which the denial is based (or a statement that such information will be provided free of charge upon request);

- a statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, or other information relevant to your claim;

- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about the procedures;

- a statement that you or the plan may have other voluntary alternative dispute resolution options, such as mediation, and that one way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency; and

- a statement describing your right to bring a civil lawsuit under federal law.

Exhaustion Requirement

You may not bring a lawsuit to recover benefits until you have exhausted the internal administrative process described above. Any participant or beneficiary can bring an action in connection with the Plan only in the District

of New Jersey. No legal action may be commenced at all unless commenced no later than one year following the issuance of a final decision on the claim for benefits, or the expiration of the appeal decision period if no decision is issued. This one-year statute of limitations on suits for all benefits will apply in any forum where you may initiate such a suit.

SECTION 12: ADDITIONAL PLAN TERMS

If You Leave the Employer

If you are an active team member and terminate employment with the Employer or one of its affiliates for any reason, you can continue to use any balances in your Dependent Care FSA and your Health Care FSA to pay expenses incurred prior to your termination. All claims must be submitted no later than March 31 following the Plan Year in which the expense is incurred. Note though that you may be eligible to continue participation in your Health Care FSA for a limited period of time, in accordance with COBRA; provided you make contributions to your Health Care FSA on an after-tax basis (see "Continuation Coverage" below for more information).

If You Return to Employment

Generally, if you terminate employment with the Employer and later return, you may make a new benefit election under the Plan if you otherwise satisfy the Plan's eligibility requirements. However, you cannot make a new election if you resume employment within 30 days of your termination and in the same Plan Year. In that case, your previous elections will be automatically reinstated.

If You Die

If you die while actively employed, your surviving spouse (or, if none, the administrator or executor of your estate) may continue to use any balances in your FSAs to obtain reimbursements for covered expenses that were incurred prior to your death. These claims must be submitted by March 31 following the Plan Year in which you die. No money may be contributed to your FSAs after your death, nor are expenses incurred by your spouse or beneficiaries after your death eligible for reimbursement.

If You Are Absent From Work

In General

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Qualified Change Event rules will apply.

Your participation in the Dependent Care FSA will be automatically cancelled during any leave of absence (paid or unpaid) as dependent care expenses are only eligible for reimbursement for care that allows you to be at work.

Continuation During Periods of Employer-Certified Disability or Leave of Absence

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

Military Leave

The Employer recognizes that team members may need to be absent from work to serve in the US military. The Employer intends to comply with USERRA and Heroes Earnings Assistance and Relief Tax Act ("HEART")). For more information on your rights under USERRA and the HEART Act, contact the HR Support Services Team.

Family Medical Leave Act

The Employer intends to comply with the FMLA and applicable regulations. If you take an FMLA leave of absence, you may be able to continue your health and welfare benefits coverage. If you elect to cancel coverage or if your coverage is cancelled due to non-payment, the Plan Administrator will automatically re-enroll you for benefits as of your return to work date using the same elections that were in effect prior to your cancellation of coverage. If you experienced a Qualified Change Event while you are on a FMLA leave of absence that would otherwise allow you to make a mid-year change in your elections, you will be allowed to change your benefit.

Notwithstanding the foregoing, in the event your Health Care FSA coverage terminated during FMLA leave, you will be permitted to elect whether to be reinstated in the Health Care FSA benefits at the same coverage level as was in effect before your FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay contributions. If you elect a coverage level that is reduced pro-rata for the period of FMLA leave, then the amount withheld from your compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health Care FSA benefits will be equal to the amount withheld prior to the period of FMLA leave.

For more information on how benefits are affected during an FMLA leave, please refer to the Employer's FMLA Policy.

Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you have continuation coverage rights as described below with respect to your Health Care FSA. You do not have continuation rights with respect to your Dependent Care FSA. (COBRA rights with respect to your group health plan coverage are provided under the Welfare Benefit Plan.)

How COBRA Continuation Works

If you elect to participate in the Health Care FSA, you have a right to choose continuation coverage for the remainder of the Plan Year if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), provided that the amount you could be entitled to receive for the remainder of the Plan Year exceeds the amount you would be required to pay for such coverage for the remainder of the Plan Year. If eligible, you may only continue coverage in the amount in effect on the day before you lost coverage; you may not alter the coverage.

COBRA Qualifying Events

If your spouse is covered under the Health Care FSA, he or she has the same right to choose continuation coverage for the remainder of the Plan Year (provided the amount he or she could be entitled to receive exceeds the amount required to be paid for such coverage for the remainder of the year) if coverage is lost for any of the following reasons:

- Your death;
- Termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment;
- Divorce or legal separation; or
- You become entitled to Medicare.

In the case of your covered dependent child, he or she has the same right to continuation coverage for the remainder of the Plan Year (provided the amount he or she could be entitled to receive exceeds the amount required to be paid for such coverage for the remainder of the Plan Year) if coverage under the Health Care FSA is lost for any of the following reasons:

- Your death;
- Termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;
- Your divorce or legal separation;
- He or she ceases to be a "dependent child" under the Plan; or
- You become entitled to Medicare.

Notification Requirements for COBRA Continuation Coverage; Other Rights

Under the law and the terms of the Plan, you or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child's loss of dependent status under the Health Care FSA within 60 days of such event.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you regarding your right to choose continuation coverage. Under the law, if you are eligible for continuation coverage, you (or your spouse or dependent child) have at least 60 days from the date you would otherwise lose coverage because of one of the events described above (or from the date you receive such notice, if later) to inform the Plan Administrator that you want continuation coverage.

If you, your spouse or your dependent child is eligible for continuation coverage and do not choose continuation coverage, your coverage under the Health Care FSA will end.

If you, your spouse, or your dependents are eligible for and choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health Care FSA to similarly situated team members or family members and to give you, your spouse, or your dependent child the opportunity to maintain continuation coverage for the remainder of the Plan Year.

When COBRA Coverage Ends

Notwithstanding the above requirements, the law provides that your continuation coverage may be cut short for any of the following reasons:

- The Employer no longer provides any group health coverage to any of its team members;
- You cease making required contributions under the Health Care FSA;
- You become covered under another healthcare flexible spending account that does not contain any exclusion or limitation with respect to any preexisting condition you have which is covered under the Health Care FSA; or
- You become entitled to Medicare.

Cost of COBRA Coverage

In general, the amount that you and your dependents pay each month for COBRA continuation coverage is equal to the full monthly Health Care FSA contributions you elected, plus an administrative fee of up to 2%. Be aware that your contributions will be made with after-tax dollars. The tax advantages available to you as an active employee (through pre-tax contributions) will no longer be available. However, by electing COBRA continuation you may access funds already contributed to pay for qualified health care expenses incurred during your participation under COBRA (that is, expenses incurred after the date on which your regular participation ends).

Qualified Medical Child Support Order

The Health Care FSA will provide benefits as required by any QMCSO, as defined in ERISA Section 609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain without charge, a copy of such procedures from the Plan Administrator.

HIPAA Privacy Rights

Under federal law, special rules apply to the privacy of your health information under the Health Care FSA. For more information about the confidentiality of your protected health information ("PHI") and how it may be used and disclosed, please refer to the Plan's Notice of Privacy Practices (the "Notice"). The Notice explains how you may access and amend your PHI, request an accounting of disclosures of your PHI, and request restrictions on disclosures of your PHI. You may request a copy of the Notice by contacting the Plan Administrator. Other policies adopted by the Plan contain standards designed to maintain the security of your PHI.

SECTION 13: PARTICIPANT RIGHTS

As a participant in the Health Care FSA, you are entitled to certain rights and protections under ERISA:

Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, and, if applicable, copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plans annual financial report ("SAR"), if applicable. The Plan Administrator is required by law to furnish each participant with a copy of the SAR. The SAR may be provided electronically.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating the plan.

The people who operate the 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, as applicable, and after exhausting the plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court after all required reviews of your claims have been completed.

If it should happen that plan fiduciaries misuse a 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 sued to pay these costs and fees. If you lose, the court may order the person 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 the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 866-444-3272.

SECTION 14: ADMINISTRATIVE INFORMATION

Plan Name	Meridian Health Cafeteria Program, a component plan of the Welfare Benefit Plan of Meridian Health
Type of Plan	Welfare
Plan Sponsor	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
Employer Identification Number	22-3471515
Plan Number	501
Plan Administrator and Named Fiduciary	Senior Vice President of Human Resources, Meridian Health 1430 Rt. 34 Neptune, New Jersey 07753
FSA Claims Administrator	WageWorks PO Box 14053 Lexington, KY 40512
Agent for Service of Legal Process	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
Plan Year	January 1–December 31
Plan Funding	This is a self-insured, unfunded welfare benefit plan. Team members and the Employer share the cost of coverage. Team members generally contribute on a pre-tax basis.

Plan Administration

The Board of Trustees of Meridian Health, or its delegate, is responsible for designating the person, committee, or entity that will serve as the Plan Administrator. Currently, the Plan Administrator is the Senior Vice President of Human Resources. The Plan Administrator shall have exclusive authority and sole and absolute discretion to interpret the Plan, to make any factual determination, to resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan in order to determine eligibility, coverage, and benefits under the Plan.

The Claims Administrator, has complete authority and sole and absolute discretion to determine whether you have incurred a covered expense for which benefits may be payable under the Plan and to determine the amount of, and administer the payment of, any such benefits under the Plan.

Benefits will be paid under the Plan only if the Plan Administrator, with regard to eligibility determination, or the Claims Administrator, as appropriate, determines in its discretion that the claimant is entitled to them. Except as otherwise provided herein, all decisions of the Plan Administrator and the Claims Administrator shall be conclusive and binding upon all similarly situated individuals having an interest in the Plan. Please note that no other person or group has any authority to interpret the terms of the Plan (including this Summary and any other documents governing the Plan) or to make any promises to you about them.

Right of Recovery

If any claim or benefit is overpaid, the plan reserves the right to recover the overpayment or to reduce future payments. The person receiving the benefit must produce any instruments or papers necessary to ensure this right of recovery.

Fraud Protection

If you knowingly and intentionally defraud the plan, file a statement of claim that contains any materially false information, conceal information in order to mislead, or commit a fraudulent act against the Plan, this is a crime and is subject to criminal and civil penalties.

Assignment of Benefits

The benefits described in this Summary are exclusively for Plan participants. Plan benefits cannot be sold, transferred or assigned for any reason except as provided by law, or as otherwise provided under the Plan.

Employment Contract—Team Member Rights Not Implied

Your participation in the Plan doesn't give you the right to be retained in employment with the Employer or one of its affiliates, nor does it interfere with the right of the Employer or its affiliates to discharge or terminate you without regard to the effect the discharge or termination would have on your rights under the Plan.

Plan Documents

This document summarizes the major features of the Plan. With respect to the Health Care FSA, it is intended to meet the requirement for a SPD under ERISA. The Employer has a copy of the Welfare Benefit Plan, which governs your rights if there is a difference between it and this Summary.

Amending and Terminating the Plan

The Employer expects to continue the Plan, but necessarily reserves the right at any time, by or pursuant to written action of its Board of Trustees, or its delegate, to amend or terminate the Plan in any and all respects including without limitation, the right to amend the Plan to reduce, change, eliminate and/or modify the type or amount of coverage or benefits provided to any class of persons receiving or entitled to receive benefits, 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.

Nondiscrimination

The Plan is subject to nondiscrimination requirements under the IRC. These nondiscrimination rules prevent the design or operation of the Plan in a way that disproportionately favors highly compensated employees. The Plan Administrator may make changes to your Plan elections during the Plan Year if you are a key employee or highly compensated individual as defined by the IRC, if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. The Plan Administrator will notify you if you are affected by any of these nondiscrimination limitations.