MERIDIAN HEALTH

Meridian Health Welfare Benefit Plan

A Partnership "TOTAL REWARDS" Program

WELFARE BENEFIT PLAN OF

MERIDIAN HEALTH

Amended and restated effective January 1, 2013

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ARTICLE I. INTRODUCTION

1.01 Purpose of Plan

The purposes of this Welfare Benefit Plan of Meridian Health (the "Plan") are to: (a) offer Employees an opportunity to obtain certain medical, dental, vision, flexible spending account, life and accident, and disability benefits; and (b) provide Employees an opportunity to pay for certain benefits on a before-tax basis.

1.02 Type of Plan

The Plan consolidates a broad range of welfare plan benefits (as defined under Section 3(1) of ERISA), some of which are provided through insurance policies with an independent insurance company, and a Cafeteria Program within the meaning of Section 125 of the Code. The Plan includes the following health and welfare benefit programs: (a) health benefits intended to comply with Section 105 of the Code (i.e., medical, dental, vision, health care flexible spending account); (b) a flexible benefits arrangement intended to comply with Section 125 of the Code; (c) a dependent care assistance program intended to comply with Section 129 of the Code; (d) life insurance benefits; (e) long-term disability benefits; (f) accidental death and dismemberment benefits, and (g) short-term disability and whole life insurance coverage described in Exhibit B. The Plan shall be administered and interpreted in a manner consistent with ERISA, the applicable provisions of the Code, and the regulations promulgated thereunder. Nothing in this Plan document, however, will subject any Covered Benefit under the Plan to ERISA if the Covered Benefit would not otherwise be covered by ERISA. For purposes of satisfying applicable nondiscrimination rules under Section 105 of the Code, each Benefit Program may be tested separately.

The Covered Benefits include those Benefits that are identified in Exhibit B, as well as any welfare benefit programs maintained by the Employer that may be added from time to time. Separate Program Documents that describe the specific benefits provided by each Benefit Program, the individuals covered by each Benefit Program, and the other terms and conditions of each Benefit Program, as amended from time to time, are incorporated herein by this reference.

If a Benefit Program is insured and there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Program Document will control. For all other Benefit Programs, if there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Plan will control (unless contrary to applicable law), except for terms exclusively applicable to a Benefit Program, which are set forth in the applicable Program Document.

1.03 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however the Company may amend or terminate the Plan or any provision of the Plan in accordance with Article XII.

1.04 Effective Date

The Plan, originally adopted effective January 1, 1998, is hereby amended and restated Plan effective January 1, 2013.

1.05 Applicability of the Plan

As amended and restated in this document, the Plan shall apply only to eligible individuals under the Plan on or after January 1, 2013, except to the extent a Benefit Program expressly covers an individual as a former Employee or as a Dependent of a former Employee, such as in the case of COBRA continuation coverage.

1.06 Annual Reporting Requirements

All Covered Benefits offered under the Plan will constitute a single plan for purposes of the annual reporting requirements of the Code and ERISA. Notwithstanding the foregoing, any separate Covered Benefit required to receive an opinion from an independent qualified public accountant pursuant to Section 103(a)(3) of ERISA will be deemed a separate employee benefit plan for purposes of the annual reporting requirements of the Code and ERISA.

ARTICLE II. DEFINITIONS

Covered Benefits are documented as provided in Exhibit B. Such documentation is incorporated by reference into this Plan document. This Article II further incorporates by reference the terms and definitions that are specific to each Covered Benefit. Definitions under this Article II will apply uniformly and without exception to all Covered Benefits, unless otherwise specified in the applicable Covered Benefit Document.

2.01 Adverse Benefit Determination

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make a benefit payment (in whole or in part). For Covered Benefits that are group health plans, this shall also include a denial, reduction, or termination of a benefit, if a failure to provide or make a benefit payment (in whole or in part) results from the application of any utilization review or because it is determined to be experimental or investigational or not medically necessary or appropriate. For Covered Benefits that are subject to the "market reform" provisions of PPACA, an Adverse Benefit Determination shall also include any rescission of coverage (as described in 45 CFR 147.128) whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

2.02 Board of Trustees

Board of Trustees means the persons, and their successors, appointed or elected to manage and direct the affairs of the Company.

2.03 Cafeteria Program

Cafeteria Program means the Covered Benefits described in Articles IV, V, VI and VII, except for life insurance coverage on the life of a Dependent, which permit eligible Employees to choose between certain benefits provided by the Employer or additional cash compensation. The Cafeteria Program is intended to qualify as a "cafeteria plan" under Code Section 125.

2.04 Civil Union

Civil Union means a civil union that is either established pursuant to applicable state law or recognized by the applicable state as a civil union.

2.05 Civil Union Partner

Civil Union Partner means a person who has established and is in a Civil Union and with respect to whom an Employee has provided the Plan Administrator with a Civil Union Certificate or Civil Union License.

2.06 Claims Administrator

Claims Administrator means the Company or the person, entity or committee appointed by the Company to administer claims pursuant to Section 8.01, as identified in Exhibit B. The Claims Administrator is a fiduciary of the Plan.

2.07 COBRA

COBRA means the provisions of Section 4980B of the Code and Sections 601 through 608 of ERISA.

2.08 Code

Code means the Internal Revenue Code of 1986, as in effect at the time with respect to which the term is used, and regulations issued thereunder.

2.09 Company

Company means Meridian Health, and any successor by merger or otherwise, any subsidiary or affiliated organization and any successor(s) of any of them that has adopted the Plan pursuant to Section 13.01 and not withdrawn pursuant to Section 13.02. All subsidiaries and affiliated organizations of Meridian Health that participate in this Plan shall be listed in Exhibit A attached hereto. For the purpose of exercising any administrative power granted under this Plan, the term "Company" shall not include such subsidiaries or affiliates.

2.10 Compensation

Compensation means the regular pay of an Employee (including bonuses, overtime pay and any amounts otherwise payable to an Employee from the Company's general assets for personal services the Employee renders during the portion of a Plan Year the Employee is eligible to participate in this Plan). This remuneration is calculated before any salary reduction/deduction contributions are taken under any employee benefit plan the Company maintains under Sections 125, 401(k) and/or 403(b) of the Code. The term Compensation does not include reimbursed expenses or remuneration payable other than in cash.

2.11 Covered Benefit

Covered Benefit means, on and after the Effective Date, any of the benefits listed in Exhibit B to the Plan. Covered Benefits incurred in, or attributable to, the period prior to the Effective Date are determined under the prior version(s) of this Plan.

2.12 Covered Benefit Document

Covered Benefit Document means the written description of the terms of each separate Covered Benefit, including but not limited to a summary plan description, schedule of benefits, benefits booklet, or insurance contract or certificate.

2.13 Covered Dependent

Covered Dependent means a Dependent of a Covered Employee whose coverage has become effective and has not terminated in accordance with the provisions of Article III.

2.14 Covered Dependent Care Expenses

Covered Dependent Care Expenses mean the expenses described in Section 7.02.

2.15 Covered Employee

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III, who has elected to participate in the Plan, and whose coverage has become effective and has not terminated in accordance with the provisions of Article III.

2.16 Covered Health Care Expenses

Covered Health Care Expenses mean those expenses described in Sections 5.02 and 5.03.

2.17 Dental Plan

Dental Plan means the dental benefit option(s) available to Covered Employees and their eligible Dependents, as described in the applicable SPD.

2.18 Dependent

Dependent means the Covered Employee's Spouse, Civil Union Partner, Domestic Partner, and/or child (as defined under the applicable Covered Benefit Document) who meets the definition of a Dependent set forth in the Covered Benefit Document for a particular Covered Benefit or, if applicable, an individual who is determined to be an alternate recipient of a Covered Employee under a qualified medical child support order ("QMCSO").

2.19 Dependent Care Flexible Spending Account

Dependent Care Flexible Spending Account means the portion of this Plan described in Article VII hereof.

2.20 Disability Plan

Disability Plan means the long-term disability benefit option(s) available to Covered Employees and their eligible Dependents, as described in the applicable SPD.

2.21 Domestic Partner

Domestic Partner means an eligible Team Member and one other person who:

a. have been living in a committed exclusive relationship of mutual caring and support for a period of at least twelve (12) months;

b. intend for the Domestic Partnership to be permanent;

c. are financially interdependent and jointly responsible for the common welfare and financial obligations of the household;

d. is not legally or ceremonially married to any other individual, and, if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased;

e. are mentally competent to enter into a contract according to the laws of the state in which they reside;

f. are 18 years of age or older;

g. are the same gender;

h. do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside, if all other applicable marriage requirements of such state law were met;

i. are not in the relationship solely for purposes of obtaining benefits; and

j. register as same sex domestic partners, if they live in a municipality or state that registers domestic partners, and provide the Plan Administrator with a copy of the registration.

An Employee must provide the Plan Administrator with a valid Domestic Partner Affidavit. Individuals who enter a domestic partnership with an Eligible Employee on or after January 1, 2014 are not eligible under the Plan.

2.22 Effective Date

The Effective Date of this amended and restated version of the Plan is January 1, 2013.

2.23 Employee

Employee means an individual who is treated as a regular employee of the Company (a) who is paid a salary, wages or other compensation by the Company; (b) who is considered by the Company to be an employee at the time of the payment of such salary, wages, or other compensation; and (c) whose salary, wages or other compensation is treated by the Company at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee's share of social security tax.

Notwithstanding the foregoing, "Employee" shall not include the following categories of individuals, even if one or more of such individuals is determined by a court, the Internal Revenue Service or any other entity under any federal or state law, rule or regulation to

be (or have been) a common law or statutory employee of the Company for some or all of the period of time in question:

a. any individual who is performing services for the Company under an independent contractor or consultant agreement or arrangement with the Employer (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee);

b. any individual who must be treated as an employee of the Company for limited purposes under the leased employee provisions of Code Section 414(n);

c. any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the plan were the subject of good faith bargaining between the individual's bargaining representative and the Company; and

d. any individual classified by the Company as a temporary or contract employee.

2.24 FMLA

FMLA means the Family and Medical Leave Act of 1993, as in effect at the time with respect to which the term is used, and valid regulations issued thereunder.

2.25 Health Care Flexible Spending Account

Health Care Flexible Spending Account means the portion of this Plan described in Article V.

2.26 Health Management Plan

Health Management Plan means any of the wellness plans established by the Company for the benefit of its Covered Employees as described in Section 9.12.

2.27 Health Savings Account

Health Savings Account or HSA means a health savings account established under Section 223 of the Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an HSA-Eligible Individual with a qualified trustee or custodian.

2.28 High Deductible Health Plan

High Deductible Health Plan means a health plan benefit option offered by the Company that is intended to qualify as a high deductible health plan under Section 223(c)(2) of the Code.

2.29 HIPAA

HIPAA means those portions of the Code and ERISA concerning group health plans that were inserted by the Health Insurance Portability and Accountability Act of 1996, P. L. 104-191.

2.30 HSA Contributions

HSA Contributions mean the contributions to a Health Savings Account described in Section 6.01 made through this Plan.

2.31 HSA-Eligible Individual

HSA-Eligible Individual means a Covered Employee who, as determined and reported to the Plan Administrator by the Covered Employee, is eligible to contribute to an HSA under Section 223 of the Code and who has elected qualifying High Deductible Health Plan coverage offered by the Company, and who: (i) is not also covered by any other health plan that is not a high deductible health plan under Section 223(c)(2) of the Code, (ii) is not enrolled in Medicare, and (iii) may not be claimed as a dependent on another person's tax return. The determination as to whether a Covered Employee is an HSA-Eligible Individual shall be made by each respective Covered Employee.

2.32 Life Insurance Plan

Life Insurance Plan means the basic and supplemental life insurance benefit option(s) available to Covered Employees and dependent life insurance option(s) available to their eligible Dependents, as described in the applicable SPD.

2.33 Medical Plan

Medical Plan means the medical benefit option(s) available to Covered Employees and their eligible Dependents, as described in the applicable SPD.

2.34 Participant

Participant means the term as defined in Section 3.02 of this Plan document.

2.35 Plan

Plan means this Welfare Benefit Plan of Meridian Health as herein set forth and as amended from time to time. Terms of the Plan in effect prior to the Effective Date are described in, and governed by, the prior version(s) of this Plan.

2.36 Plan Administrator

Plan Administrator means the person(s) or entity designated in, or appointed pursuant to, Section 11.01.

2.37 Plan Election

Plan Election means the written or electronic election with respect to the Covered Benefits specified in the form or forms filed by an Employee with the Plan Administrator (or a representative of the Plan Administrator) in accordance with Article III.

2.38 Plan Sponsor

Plan Sponsor means Meridian Health.

2.39 Plan Year

Plan Year means the 12-month period beginning January 1 and ending December 31.

2.40 PPACA

PPACA means the Patient Protection and Affordable Care Act of 2010 and related guidance.

2.41 Qualifying Person

Qualifying Person means:

a. a dependent of the Covered Employee (as defined in Section 152(a)(1) of the Code) who has not attained age 13, or

b. a dependent of the Covered Employee (within the meaning of Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than one-half of such taxable year, or

c. the Covered Employee's Spouse, if the Spouse is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than one-half of such taxable year.

Notwithstanding the foregoing, if (1) Section 152(e) of the Code (regarding divorced or separated parents) is applicable to a child of a Covered Employee, and (2) such child is under the age of 13 or is physically or mentally incapable of self-care, then such child shall be deemed a Qualifying Person (described in (a) or (b) above) with respect to the Covered Employee if such Covered Employee is the custodial parent of the child within the meaning of Section 152(e)(4)(A) of the Code.

The Plan Administrator may require such proof of an individual's disability as it may, in its sole discretion, determine from time to time.

2.42 Salary Reduction Amount

Salary Reduction Amount means the amount designated by the Covered Employee in a Plan Election authorizing the Company to reduce the Covered Employee's Compensation

received during the Plan Year or portion of the Plan Year to which the Plan Election relates by the amount so designated and to contribute such amount, as a before-tax employer contribution or an after-tax employee contribution (as determined by the Company), on behalf of the Covered Employee toward the cost of the Covered Benefits specified by the Covered Employee in his or her Plan Election for each such type of contribution (to the extent permitted under the Plan).

2.43 Spouse

Spouse means the person lawfully married to a Covered Employee under the laws of any domestic or foreign jurisdiction where such individual and Covered Employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

2.44 Summary Plan Description

Summary Plan Description or SPD means each Covered Benefit summary plan description distributed to Participants

2.45 Vision Plan

Vision Plan means the vision benefit option(s) available to Covered Employees and their eligible Dependents, as described in the applicable SPD.

2.46 USERRA

USERRA means the Uniformed Services Employment and Reemployment rights Act of 1974, as in effect at the time with respect to which the term is used, and regulations issued thereunder.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.01 Eligibility

For each Covered Benefit, an Employee shall be eligible to participate according to the terms provided in the applicable Program Document. Generally, the following Employees may be eligible to participate in the Covered Benefits, subject to the eligibility terms described in the applicable Program Document:

a. a Status 1 full-time employee who is regularly scheduled to work 36 or more hours per week, or

b. a Status 2 part-time employee who is regularly scheduled to work 20 or more hours but less than 36 hours per week.

Employees classified as Per Diem are generally not eligible to participate in the Plan except to the extent an applicable Program Document provides otherwise.

In addition, to be eligible to participate in any of the Covered Benefits set forth in Exhibit B, an eligible Employee must satisfy any additional eligibility and/or waiting period requirement that applies to such Covered Benefit (as may be described in an applicable Covered Benefit Document) and must complete the necessary steps to enroll in such Covered Benefit.

Notwithstanding anything to the contrary herein, Employees covered by a collective bargaining agreement with the Company shall not be eligible to participate in the Plan unless the terms of such agreement specifically provide otherwise.

3.02 Enrollment and Participation

a. Participation

"Participant" means (i) any eligible Employee who elects to participate in a Covered Benefit in accordance with its terms and conditions, and has not for any reason become ineligible to participate further in that Covered Benefit (Participant includes a former employee who is entitled to benefit payments under a Covered Benefit), (ii) any individual in a category that is specifically designated in a Program Document as eligible for participation in the applicable Covered Benefit, provided that such individual elects to participate in the Covered Benefit in accordance with its terms and conditions and has not for any reason become ineligible to participate further in that Covered Benefit, and (iii) any Dependents of a Covered Employee who are properly enrolled in the Covered Benefit. Except as discussed in this Article III, the participation policy for each Participating Program is found in the applicable Program Document. Participation

b. Initial Enrollment

An Employee meeting the eligibility requirements of Section 3.01 above may elect to participate in the Plan by filing a properly completed Plan Election with the Plan

Administrator (or the representative of the Plan Administrator) within 31 days following the Employee's initial eligibility date. Provided that the Employee properly completes and submits a Plan Election within this timeframe, (i) the Employee's coverage under the Plan will be effective as of the first day of the month following the Employee's initial eligibility date, and (ii) the Employee's Compensation will be reduced in the amount specified in the Plan Election beginning with the first pay period following the date on which the Plan Election is submitted to the Plan Administrator (or the representative of the Plan Administrator) for which such reductions are administratively feasible based on payroll schedules, as determined in the sole discretion of the Plan Administrator. Any eligible Employee who fails to file a properly completed Plan Election with the Plan Administrator (or the representative of the Plan Administrator) shall be deemed to elect not to participate in any of the Covered Benefits for which an affirmative election is required under the Plan.

c. Annual Enrollment Periods

In addition, during any annual enrollment period, any Employee meeting the eligibility requirements of Section 3.01 above may prospectively elect to continue or modify his or her Plan participation effective as of the first day of any Plan Year by filing a properly completed Plan Election with the Plan Administrator (or the representative of the Plan Administrator) on or before the applicable deadline.

d. Special Enrollment Periods

(i) If an Employee declines enrollment for himself or herself or his or her Dependents because of other health insurance coverage, he or she shall be able to enroll himself or herself and his or her Dependents in the Medical Plan by filing a properly completed Plan Election with the Plan Administrator (or the representative of the Plan Administrator) within 30 days after such other coverage ends and such other coverage was lost due to (i) the loss of eligibility for such other coverage, (ii) the cessation of employer contributions for such other coverage, or (iii) the exhaustion of COBRA coverage. Coverage shall commence on the first day of the month following the date on which such Plan Election is received.

(ii) If an Employee adds a new Dependent as a result of marriage, entering into a Civil Union or, prior to January 1, 2014, a Domestic Partnership, birth, adoption or placement for adoption, the Employee shall be able to enroll himself or herself and his or her new Dependents, if otherwise eligible, in the Medical Plan by filing a properly completed Plan Election with the Plan Administrator (or the representative of the Plan Administrator) within 30 days after the marriage, birth, adoption or placement for adoption. In the case of an enrollment due to marriage or entering into a Civil Union or, prior to January 1, 2014, a Domestic Partnership, coverage shall commence on the first day of the month following the date of the marriage or Civil Union or Domestic Partnership. In the case of an enrollment due to birth, adoption or placement for adoption, coverage shall commence as of the date of such birth, adoption or placement for adoption and continue for a period of 30 days thereafter, but continued coverage beyond that date shall require that the Eligible Employee file a properly completed Plan

Election with the Plan Administrator (or the representative of the Plan Administrator) within 30 days of such birth, adoption or placement for adoption.

(iii) If an Employee or a Dependent (1) loses Medicaid or Children's Health Insurance Plan ("CHIP") coverage as a result of a loss of eligibility for such coverage or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP, such Employee shall be able to enroll himself or herself and his or her Dependents in the Medical Plan by filing a properly completed Plan Election with the Plan Administrator (or the representative of the Plan Administrator) within 60 days after the loss of such coverage or premium assistance eligibility. Coverage shall commence on the first day of the month following the date on which such Plan Election is received.

e. Effect of Failure to Change Existing Election

Elections under this Plan are automatically renewable by their terms, other than elections relative to the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. In such case, if a Covered Employee fails to make a new Plan Election for the Plan Year but has a prior valid Plan Election on file with the Plan Administrator (or the representative of the Plan Administrator), the Covered Employee's prior Plan Election shall continue in effect until revoked or modified in accordance with this Article III and shall be adjusted automatically to reflect any increase or decrease, effective as of the first day of the Plan Year, in the employee contributions for the coverages elected under Section 4.01(c) and/or (e). If no Plan Election is made with respect to the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account, the Covered Employee shall be deemed to have elected no coverage with respect to such benefits.

f. Waiver of Enrollment Deadline

The Plan Administrator (or the representative of the Plan Administrator) may, in its discretion, waive the above deadlines for an Employee who is absent due to illness or injury, or otherwise unavailable due to absence while on business assignment for the Company on the date the Plan Election is due; provided, however, that any waiver of deadlines for elections involving Covered Benefits under this Plan is subject to waiver of any corollary deadlines for the related Compensation reduction election as set forth in Article IV.

g. Effect on Compensation

An Employee's Plan Election made under this Article III, or any revocation or modification thereof, shall not apply to Compensation already actually or constructively received by such Employee.

3.03 Mid-year Revocation or Modification of Election

a. General Rule

Plan Elections may not be revoked or modified during a Plan Year with respect to the remainder of that same Plan Year except as specifically provided in this Article III.

b. Change in Status

A Covered Employee may revoke his or her Plan Election mid-year and make a new Plan Election for the remainder of the Plan Year upon the occurrence of any of the change in status events listed in Section 3.03(b)(i) below provided that such new Plan Election satisfies the consistency rule contained in Section 3.03(b)(ii) below.

(i) Change in Status Events

The following are change in status events under the Plan:

(A) Change in Legal Marital Status: Includes marriage, entering into or dissolving a Civil Union, entering into (prior to January 1, 2014) or dissolving a Domestic Partnership, death of Spouse, Civil Union Partner, or Domestic Partner, divorce, legal separation, or annulment.

(B) Change in Number of Tax Dependents: Includes birth, adoption, placement for adoption, or death of a dependent.

(C) Employment Status Change: For the Covered Employee or his or her Dependent: Commencement or termination of employment, strike or lockout, commencement or return from an unpaid leave of absence, or change in worksite. Also if the eligibility conditions under the plan of the employer of any such individual depends on his or her employment status and a change in his or her employment status changes or terminates his or her eligibility under such plan, it is a change in employment status for purposes of this Plan (e.g., salaried to hourly, full-time to part-time, etc.).

(D) Dependent Becomes or Ceases to be Eligible: An event causing the Covered Employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstances; and

(E) Residence Change: A change in the place of residence of the Covered Employee or Dependent.

(ii) Consistency Rule

A Covered Employee's mid-year Plan Election change must be on account of and corresponding with a change in status listed in Section 3.03(b)(i) that affects eligibility for coverage under an employer's plan. The consistency rule shall be applied under the Plan in accordance with Treasury Regulation Section 1.125-4.

c. Change in Cost or Coverage

A Covered Employee's Plan Election (other than the portion relating to the Health Care Flexible Spending Account) may be modified for the remainder of the Plan Year for any of the following changes in cost or coverage:

(i) Insignificant Cost Changes

If the cost of any portion of this Plan (other than the Health Care Flexible Spending Account) increases or decreases insignificantly (as determined by the Plan Administrator) during the Plan Year, the contributions of Covered Employees under such portion shall be automatically increased or decreased correspondingly for the remainder of the Plan Year.

(ii) Significant Cost Changes

If the cost of any portion of the Plan (other than the Health Care Flexible Spending Account) in which the Employee participates significantly increases during a Plan Year, the Covered Employee either may increase his or her Salary Reduction Amount under the Plan for the remainder of the Plan Year or may revoke his or her Plan Election and, in lieu thereof, prospectively elect another option of the same type with a corresponding Salary Reduction Amount for such coverage or drop coverage if no other option providing similar coverage is available. If the cost of any portion of the Plan (other than the Health Care Flexible Spending Account) significantly decreases during a Plan Year, a Covered Employee may change his or her Salary Reduction Amount under the Plan to reflect the added cost of the coverage for a previously unenrolled Dependent if permitted by the Covered Benefit; or an Employee who is eligible but not enrolled in the Plan may enroll in such coverage (and may enroll his or her Dependent) and change his or her Salary Reduction Amount accordingly, if permitted by the Covered Benefit.

(iii) Significant Curtailment

If, during the Plan Year, coverage under any portion of the Plan (other than the Health Care Flexible Spending Account) is significantly curtailed or ceases, an affected Covered Employee may revoke his or her Plan Election and prospectively elect a different option of the same type with a corresponding Salary Reduction Amount for the remainder of the Plan Year or, if there is no similar coverage option, drop coverage. If a Plan option is added during the Plan Year, affected Covered Employees may prospectively elect such option with a corresponding change to the Salary Reduction Amount for the remainder of the Plan Year.

(iv) Coverage Improvement

If, during the Plan Year, coverage under any portion of the Plan (other than the Health Care Flexible Spending Account) is significantly improved, as determined by the Plan Administrator, or a new coverage option becomes available under any portion of the Plan, both Covered Employees and eligible Employees who are not enrolled in the Plan may change his or her Salary Reduction Amount to reflect the election of a new coverage option (and a related cancellation of a prior coverage option)

or the addition of a Dependent, both to the extent permitted by the Covered Benefit. An eligible but not participating Employee may change his or her Salary Reduction Amount under the Plan to reflect the election (for the Employee and his or her Dependents) of a new coverage option or the election of coverage under the improved option, both to the extent permitted by the Covered Benefit.

(v) Change in Coverage of Dependent Under Other Employer's Plan

If, during the Plan Year, the Covered Employee's Dependent makes an election change under his or her employer's plan or makes an election during an annual enrollment period where the plan year of such other employer's plan differs from that of this Plan, then a Covered Employee may make a corresponding prospective change to his or her Plan Election and related Salary Reduction Amount for the remainder of the Plan Year.

d. HIPAA Special Enrollment Rights

An Employee who is entitled to enroll himself or herself or a dependent in group health plan coverage as a result of the HIPAA special enrollment rights contained in Section 701(f) of ERISA or Section 9801(f) of the Code applies, and who does so, may modify his or her Plan Election and Salary Reduction Amount correspondingly for the affected Covered Benefit(s) under this Plan as determined by the Plan Administrator (or the representative of the Plan Administrator). Special enrollment rights are described in Section 3.02(d) above.

e. Judgment, Decree or Order

If a judgment, decree or order (including a qualified medical child support order under Section 609(c) of ERISA) requires the Employee to provide group health plan coverage for a child, then the Employee may modify his or her Plan Election and Salary Reduction Amount to pay any additional costs for coverage for the child. If a judgment, decree or order (including a qualified medical child support order under Section 609(c) of ERISA) requires an Employee's Spouse or former Spouse to provide group health plan coverage for a child and that individual does so, then the Employee may modify his or her Plan Election and Salary Reduction Amount to reflect any reduction in costs for coverage for the child.

f. Entitlement to Medicare or Medicaid

If the Employee or Dependent becomes enrolled in or terminates coverage under Medicare Part A or Part B or Medicaid, other than coverage consisting solely of benefits under the Plan for distribution of pediatric vaccines, the Covered Employee may revoke or modify his or her Plan Election and Salary Reduction Amount to reflect any commencement or cancellation of such individual's group health or HMO coverage.

g. COBRA or USERRA Continuation of Group Health Plan Coverage

A Covered Employee who elects COBRA continuation of the underlying group health plan coverage to which Section 4.01(c) relates and in which he or she participates shall be entitled to modify his or her Plan Election to increase (via after-tax contributions) the amount of his or her contributions to the extent the Plan Administrator must so permit under Section 4980B of the Code or under USERRA in order to effectuate such continuation.

h. Leave of Absence

Whether and to what extent a Covered Employee who takes an unpaid leave of absence can continue or change benefit elections will be determined in accordance with the Company's leave of absence policies and procedures.

i. Health Savings Account Changes

A Covered Employee may revoke or modify his or her Plan Election relative to HSA Contributions at any time by filing a Plan Election with the Plan Administrator (or the representative of the Plan Administrator). Such change will become effective as soon as administratively practicable following receipt of the modified Plan Election.

j. Revocation of Election under Medical Plan to purchase a Qualified Health Plan through Exchange

Effective for Plan Years beginning on or after January 1, 2015, a Covered Employee may prospectively revoke his or her Plan Election for Medical Plan coverage that provides minimum essential coverage (as defined in section 5000A(f)(1) of the Code) if the conditions under either (i) or (ii) below are met:

(i) Conditions for Revocation due to Reduction in Hours of Service:

(A) The Covered Employee has been in an employment status under which he or she was reasonably expected to average at least 30 hours of service per week and there is a change in his or her status so that he or she will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Covered Employee ceasing to be eligible under the Medical Plan;

(B) The revocation of the Plan Election for the Medical Plan coverage corresponds to the intended enrollment of the Covered Employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked; and

(C) The Covered Employee provides written notice to the Plan Administrator within 31 days of the change in status.

The Plan Administrator may rely on the reasonable representation of a Covered Employee that the Covered Employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked in accordance with (i)(B) above.

(ii) Conditions for Revocation due to Enrollment in a Qualified Health Plan:

(A) The Covered Employee is eligible for a "Special Enrollment Period" (as defined in section 1311(c)(6)(C) of PPACA) to enroll in a "Qualified Health Plan" (as defined in section 1301(a) of PPACA) through an "Exchange" (as defined in section 2791(d)(21) of the Public Health Service Act) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Covered Employee seeks to enroll in a Qualified Health Plan through an Exchange during the Exchange's annual open enrollment period;

(B) The revocation of the Plan Election for the Medical Plan coverage corresponds to the intended enrollment of the Covered Employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked; and

(C) The Covered Employee provides written notice to the Plan Administrator (i) prior to the end of the applicable Special Enrollment Period or annual open enrollment period or (ii) if the Covered Employee has enrolled in a Qualified Health Plan for new coverage during such Special Enrollment Period or annual open enrollment period, within 31 days following such enrollment.

The Plan Administrator may rely on the reasonable representation of a Covered Employee that the Covered Employee and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

k. Effective Date of Election Changes

Except as provide in Section 3.02(d) and 3.03(i) above, Plan Elections revoked or modified under this Section 3.03 shall become effective on the first day of the month following the date on which such Plan Election is received, provided such Plan Election is received by the Plan Administrator (or the representative of the Plan Administrator) within 31 days after the event described in this Section 3.03.

l. Other Permitted Election Changes

A Covered Employee may revoke or modify his or her Plan Election mid-year upon the occurrence of any other change in status or other circumstances permitted

under Section 125 of the Code, as determined by the Plan Administrator in its sole discretion.

m. Restrictions on Mid-Year Election Changes.

Notwithstanding anything herein to the contrary:

(i) A Covered Employee may not modify his or her Plan Election mid-year to add a new Civil Union Partner or Domestic Partner (or the children of such individual) if the Covered Employee dissolved a Civil Union or Domestic Partnership at any time during the prior 12 months. Individuals who enter a domestic partnership with an Eligible Employee on or after January 1, 2014 are not eligible under the Plan.

(ii) A Covered Employee may not modify his or her Plan Elections under the Life Insurance Plan or Disability Plan mid-year. A Covered Employee may only modify such elections during the annual enrollment period, subject to any evidence of insurability requirements.

3.04 Termination of Participation

a. Except as may be provided otherwise in Covered Benefit Document, a Covered Employee's participation in the Plan will terminate if:

(i) He or she revokes his or her Plan Election in its entirety and fails to make a new Plan Election;

(ii) He or she no longer satisfies the eligibility requirements set forth in Section 3.01;

(iii) He or she terminates employment with the Company; or

(iv) The Plan is terminated or is amended so as to no longer apply to the Employee.

A Covered Employee's participation in the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account shall end on the date the Covered Employee's employment with the Company terminates.

b. Except as may be provided otherwise in an SPD, a Covered Dependent's participation in the Plan will terminate if:

(i) The individual no longer meets the definition of Dependent set forth in Section 2.16;

(ii) Contributions for the cost of such Dependent's coverage are not made;

(iii) The Dependent becomes a participant in the Plan as a Covered Employee;

(iv) The Covered Employee's participation terminates;

(v) The Dependent dies; or

(vi) The Plan is terminated or is amended in a manner that it no longer applies to the Dependent.

3.05 Rescission of Coverage

With respect to the Medical Plan, a cancellation or discontinuance of coverage that has a retroactive effect (e.g., a cancellation that either treats a policy as void from the time of the Covered Employee's (or Covered Dependent's) enrollment, or voids benefits paid up to a year before the cancellation) is allowable under the Plan only (a) if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required contributions, or (b) under PPACA or any other applicable guidance issued thereunder, such cancellation or discontinuance of coverage is not considered to be a prohibited rescission. The Plan may rescind coverage under the Plan if the Covered Employee (or Covered Dependent) performs an act, practice, or omission that constitutes fraud in an enrollment form or in a claim for benefits, or makes an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to the Covered Employee's (or Covered Dependent's) eligibility for benefits. The Plan Administrator shall provide at least 30 days advance written notice to the Covered Employee (or Covered Dependent) if the Covered Employee (or Covered Dependent) would be affected before coverage will be rescinded. Any rescission of coverage shall be treated as an Adverse Benefit Determination.

3.06 Rehires

A Covered Employee who terminates and resumes employment within 30 days shall resume his or her prior Plan Election. A Covered Employee who terminates and resumes employment more than 30 days later may make a new Plan Election for the remainder of the Plan Year as if each Employee is a new employee, except as required otherwise by law.

ARTICLE IV. COVERED BENEFITS

4.01 Section 125 Plan Elections

As described in Article III, a Covered Employee may elect to participate in one or more Covered Benefits and to pay for any required employee contributions towards the cost of such Covered Benefit(s) as provided under this Article IV and in accordance with the requirements of Section 125 of the Code. The Covered Employee's choice of Covered Benefits, and allocation of his or her Compensation among the choices below, shall be indicated in his or her Plan Election. The Covered Employee's Compensation will be reduced in an amount equal to the Covered Employee's share of the benefit cost under the applicable Covered Benefit(s), and an amount equal to the reduction will be contributed by the Company towards the cost of the applicable Covered Benefit(s). The balance of the cost of each such benefit will be paid by the Company with nonelective contributions. Notwithstanding the foregoing, a Covered Employee who elects family coverage with respect to his or her Dependent(s) may contribute to the cost of family coverage by automatic pre-tax reduction of the Covered Employee's Compensation only to the extent that the Dependent(s) is the Covered Employee's Spouse, child (as defined in Section 152(f)(1) of the Code) who as of the end of the taxable year has not attained age 27, or other eligible Dependent who meets the definition of dependent in Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

a. Cash

In accordance with Article III, a Covered Employee may elect to receive cash Compensation rather than make before-tax contributions or after-tax contributions via Salary Reduction Amount to any Covered Benefits listed in (c), (d), or (e) below.

b. Waiver of Medical Plan and/or Dental Plan Coverage

During each annual enrollment period, a Covered Employee who waives medical and/or dental coverage under the Plan and provides proof of such coverage under another employer's plan or otherwise may be eligible to receive a periodic amount of additional taxable Compensation. The amount of such additional Compensation, if any, will be determined by the Company and communicated to Employees eligible for such waiver benefit in enrollment materials.

c. Before-Tax Premiums

In accordance with Article III and this Article IV, a Covered Employee may elect, in lieu of Compensation, to participate in one or more of the following Covered Benefits and to contribute towards the cost of coverage under such Covered Benefits from Compensation earned during the Plan Year or portion of the Plan Year to which the Covered Employee's Plan Election relates:

(i) before-tax payment of required Employee contributions towards the cost of coverage under the Medical Plan;

(ii) before-tax payment of required Employee contributions towards the cost of coverage under the Dental Plan;

(iii) before-tax payment of required Employee contributions towards the cost of coverage under the Vision Plan;

(iv) before-tax payment of Employee contributions to an HSA that is associated with an option under the Medical Plan that constitutes a High Deductible Health Plan; and

(v) before-tax payment of required Employee contributions towards the cost of coverage under any other optional benefit plans made available by the Company from time to time, if contributions for such coverage can be made on a before-tax basis, as determined by the Company in accordance with Section 125 of the Code.

d. Flexible Spending Accounts

In accordance with Article III and this Article IV, a Covered Employee also may elect, in lieu of Compensation, to participate in one or more of the following Covered Benefits and to contribute towards the cost of coverage under such Covered Benefits from Compensation earned during the Plan Year or portion of the Plan Year to which the Covered Employee's Plan Election relates:

(i) before-tax contributions to a Health Care Flexible Spending Account, as indicated by the sum of the appropriate portion of the Covered Employee's Salary Reduction Amount so allocated and designated in his or her Plan Election, which sum shall not exceed the maximum Covered Health Care Expenses available under Article V; and

(ii) before-tax contributions to a Dependent Care Flexible Spending Account, as indicated by the sum of the appropriate portion of the Covered Employee's Salary Reduction Amount so allocated and designated in his or her Plan Election, which sum shall not exceed the maximum Covered Dependent Care Expenses available under Article VII.

e. After-Tax Premiums

In accordance with Article III and this Article IV, a Covered Employee may elect, in lieu of Compensation, to participate in one or more of the following Covered Benefits and to contribute towards the cost of coverage under such Covered Benefits from Compensation earned during the Plan Year or portion of the Plan Year to which the Covered Employee's Plan Election relates:

(i) after-tax payment of required Employee contributions towards the cost of coverage under the Life Insurance Plan;

(ii) after-tax payment of required Employee contributions towards the cost of coverage under the Disability Plan;

(iii) after-tax payment of required Employee contributions towards the cost of coverage under the accident insurance, cancer indemnity insurance, critical illness insurance, short-term disability insurance, and whole life insurance (with long-term care rider) described in Exhibit B; and

(iv) after-tax payment of required Employee contributions towards the cost of coverage under any other optional benefit plans made available by the Company from time to time, if contributions for such coverage can be made on an after-tax basis, as determined by the Company.

4.02 Dependent Life Insurance

Eligible Employees may elect coverage under the Life Insurance Plan for dependent life insurance available to their eligible Dependents. The Employee's Compensation will be reduced, on an after-tax basis, in an amount equal to the Employee's contribution for such coverage.

4.03 Automatic Benefits

Covered Employees may automatically receive coverage under the Disability Plan and/or the basic life insurance coverage under the Life Insurance Plan as determined by the Company from time to time in its sole discretion.

4.04 Limitation on Salary Reduction Amounts

If the Plan Administrator (or the representative of the Plan Administrator) determines, with respect to any Plan Year, that the Plan is failing or may fail to satisfy any nondiscrimination requirement imposed by Sections 125, 105(h) and 129 of the Code, the Plan Administrator (or the representative of the Plan Administrator) shall take such action as it deems appropriate, under rules uniformly applicable to similarly situated Covered Employees, to ensure compliance with such requirement or limitation. Such action may include imposing a pro rata reduction on the Salary Reduction Amounts of all highly compensated employees or all key employees, as appropriate, sufficient to assure compliance with such nondiscrimination requirement.

4.05 No Assignment of Benefits

Except as provided in Article VIII, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. The Plan Administrator may elect to pay benefits directly to a health care provider unless the payment has already been made by the Covered Employee; however, the payment of benefits directly to a health care provider, if at all, shall be done as a convenience to the Covered Employee and shall not constitute an assignment of benefits under the Plan.

4.06 Disclaimer

The Company makes no assertion or warranty about whether the cost of Covered Benefits under the Plan will be excludable from a Covered Employee's gross income for federal or state income tax purposes.

ARTICLE V. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

5.01 Health Care Flexible Spending Account Benefits

A Covered Employee who has elected to participate in the Health Care Flexible Spending Account shall be entitled to benefits thereunder to the extent specified in this Article V. Benefits under the Health Care Flexible Spending Account portion of the Plan shall consist of reimbursement of Covered Health Care Expenses described in Section 5.02. A Covered Employee shall be entitled to reimbursement for eligible medical care expenses that he or she incurs during the Plan Year for his or her own health care and the health care of his or her eligible Dependents. The maximum benefits payable to any Covered Employee under the Health Care Flexible Spending Account for any Plan Year shall not exceed the lesser of:

a. the total contributions designated by the Covered Employee as allocable to the Health Care Flexible Spending Account for the Plan Year; and

b. the eligible Covered Health Care Expense claims made on the Health Care Flexible Spending Account for the Plan Year.

Benefits up to this maximum shall be payable for Covered Health Care Expense claims, without regard to the Participant's Health Care Flexible Spending Account balance at such time, even if the claim exceeds the amount credited to that date under such Account and thereby causes a negative Health Care Flexible Spending Account balance.

The maximum salary reduction contribution that a Covered Employee may make to the Health Care Flexible Spending Account for a Plan Year is $2,500 (subject to annual adjustments for inflation in accordance with Code Section 125 beginning January 1, 2014, if adjusted by the Plan Administrator as reflected in the applicable Covered Benefit Document). A Covered Employee's election under the Health Care Flexible Spending Account for a Plan Year shall not be less than a minimum of $130 for any Plan Year.

5.02 Covered Health Care Expenses

Subject to the limits contained in Article IV and Section 5.01, Covered Health Care Expenses under the Health Care Flexible Spending Account are expenses that are:

a. incurred by:

(i) the Covered Employee,

(ii) the Covered Employee's Spouse,

(iii) the Covered Employee's dependent(s) as defined in Section 152 of the Code and determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof (any child to whom Section 152(e) of the Code applies shall be treated as a dependent of both parents for purposes of this subsection), or

(iv) a "child" of the Covered Employee as defined in Section 152(f)(1) of the Code who as of the end of the taxable year has not attained age 27.

b. incurred while the Employee is a Covered Employee and participating in the Health Care Flexible Spending Account (an expense is deemed to be incurred at the time the care and/or services to which the expenses relate are provided, not the date they are charged, billed, or paid);

c. incurred for "medical care" as defined in Sections 213(d)(1)(A) and (B) of the Code (regardless of any dollar limits on deductions under that statute); provided that expenses for the following are excluded:

(i) long-term care services under Section 213(d)(1)(C) of the Code,

(ii) insurance under Section 213(d)(1)(D) of the Code, and

(iii) medicines and drugs that are available without a prescription (*i.e.*, over-the-counter), unless such medicine or drug is insulin, or is prescribed by a health care professional who is legally authorized to issue the prescription and further provided that the Plan Administrator shall have the sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to the prescription rule and whether the requirement of a prescription has been satisfied; and

d. not reimbursed by any other source, including by any prepaid health coverage, group health plan, medical insurance, or tax-free distribution from a Medical Savings Account (MSA).

5.03 Limited Purpose Health Care Flexible Spending Account in Connection with High Deductible Health Plan Coverage

A Covered Employee who elects a Medical Plan option that is a High Deductible Health Plan and includes a Health Savings Account under Article VI, may also elect to participate in a "limited purpose" Health Care Flexible Spending Account as described in this Section 5.03 (a "Limited Purpose Flexible Spending Account"). Such a Covered Employee may not elect to participate in a Health Care Flexible Spending Account that is not described in this Section 5.03, and this Section 5.03 shall supersede the rules in Section 5.02 to the extent any inconsistency arises. The Limited Purpose Flexible Spending Account is a specific type of account under the Health Care Flexible Spending Account and is intended to be a "self-insured medical reimbursement plan" within the meaning of Section 105(h) of the Code, a flexible spending arrangement within the meaning of Treasury Regulation Section 1.125-5, and a limited-purpose health flexible spending arrangement within the meaning of Treasury Regulation Section 1.125-5(m). The Plan Administrator will take whatever steps are necessary to maintain and operate the Limited Purpose Flexible Spending Account as a "nondiscriminatory" plan within the meaning of Sections 105(h) and 125 of the Code. The other provisions of the Plan shall apply, as needed, to complete the terms of such Limited Purpose Flexible Spending Account.

Subject to the limits contained in Article IV and Section 5.01, Covered Health Care Expenses under a Limited Purpose Flexible Spending Account include only expenses that both:

a. Are incurred for vision care or dental care that constitutes "permitted coverage" under Section 223(c)(1)(B) of the Code; and

b. Otherwise satisfy the requirements under Section 5.02 to be considered Covered Health Care Expenses.

5.04 Ledger Accounts

a. Establishment of Ledger Accounts

The Company, the Plan Administrator, or the representative of the Plan Administrator shall establish and maintain on its books a ledger account for each Plan Year with respect to each Covered Employee in the Health Care Flexible Spending Account.

b. Credits to Ledger Accounts

On the first day that the Covered Employee's Plan Election under the Health Care Flexible Spending Account becomes effective with respect to the Plan Year, the ledger account maintained on behalf of such Covered Employee with respect to the Health Care Flexible Spending Account shall be credited with an amount equal to the entire annual amount designated by the Covered Employee in his or her Plan Election as described under Section 5.01. Forfeitures reallocated in accordance with Section 5.05 also may be credited to the ledger accounts maintained for Covered Employees.

All amounts credited to each such ledger account shall be the property of the Company and shall not be made available to the Covered Employee unless and until paid out in accordance with Article VIII.

c. Debits to Ledger Accounts

Subject to Section 5.05, a Covered Employee's ledger account shall be debited from time to time by an amount equal to any payment, to or for the benefit of the Covered Employee with respect to whom such ledger account was established, of Covered Health Care Expenses incurred by the Covered Employee in the Plan Year and claimed in a timely manner pursuant to Article VIII.

In no event shall the amount debited at any time for Covered Health Care Expenses incurred during a Plan Year exceed:

(i) the amount credited, in accordance with Section 5.04(b) and by operation of Section 5.05, to the Covered Employee's ledger account for such Plan Year as of the date such Covered Health Care Expenses are incurred, minus

(ii) the aggregate amount of Covered Health Care Expenses that already have been debited to such individual's ledger account for such Plan Year in accordance with this Article V.

5.05 Forfeiture Provision and Carryover Feature

Effective as of the last day of the Plan Year or as of any earlier date on which the Covered Employee terminates participation in the Health Care Flexible Spending Account, the Plan Administrator (or the representative of the Plan Administrator) shall determine whether the amount of Covered Health Care Expenses paid or payable to the Covered Employee for such Plan Year is less than the amount credited to the Covered Employee's ledger account for such Plan Year. Any remaining amount credited to the ledger account maintained on behalf of the Covered Employee as of such date after processing all timely and valid claims submitted in accordance with Article VIII shall be forfeited and Covered Employees may not cash out such forfeitures or apply them toward other Plan benefits.

Notwithstanding the previous sentence,

a. A Covered Employee shall be entitled to submit, after the close of the Plan Year but no later than March 31 of the following calendar year, claims for reimbursement out of any remaining amounts credited to his or her ledger account attributable to the Plan Year in which the expenses were incurred, and such remaining credited amount shall not be forfeited until the date such limited period ends;

b. If the Health Care Flexible Spending Accounts of Covered Employees have an experience gain with respect to a Plan Year, the excess of credited amounts and income over total claim reimbursements and administrative costs may, at the discretion of the Plan Administrator (or the representative of the Plan Administrator), be used to cover the administrative expenses of the Plan, be used to reduce required contributions for the following Plan Year, be returned on a reasonable and uniform basis to Covered Employees, or be used as otherwise permitted under Section 125 of the code and the regulations issued thereunder. Experience gains may not be allocated to Covered Employees based on their individual claims experience; and

c. For Plan Years beginning on or after January 1, 2014, a Covered Employee shall be permitted to carry over to the immediately following Plan Year an amount that is equal to the lesser of (A) any unused credit balance as of the end of the immediately preceding Plan Year in his or her Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account (after the date specified in subsection a.), or (B) $500 (such amount, the "Carryover Amount"). Any credit balance in excess of the Carryover Amount remaining after the expiration of the period for submitting claims for the Plan Year shall be forfeited as provided by subsection b. Amounts carried over to a Participant's Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account for a Plan Year shall be in addition to Employee contributions made for that Plan Year.

In the case of a Participant who elects a elects a Medical Plan option that is a High Deductible Health Plan and includes a Health Savings Account under Article VI for a Plan Year into which a Carryover Amount is available, the Covered Employee must waive the Carryover Amount before the beginning of such Plan Year, on a form available from the Plan Administrator, or the Covered Employee will not be eligible for a Health Savings Account.

A Covered Employee's unused credit balance in his or her Health Care Flexible Spending Accounts at the end of a Plan Year may be used (i) for expenses incurred in that Plan Year, but only if claimed before the date specified in subsection a., or (ii) to the extent of the permitted Carryover Amount, for expenses that are incurred at any time in the subsequent Plan Year.

5.06 COBRA Continuation Coverage

COBRA continuation coverage will be provided under the Health Care Flexible Spending Account Program as described in Article IX. However, notwithstanding anything in this Section 5.06 or Article IX to the contrary, a qualified beneficiary will be offered the opportunity to elect COBRA coverage for the Health Care Flexible Spending Account Program only if, as of the qualifying event date, the maximum benefit available to the qualified beneficiary for the rest of the Plan Year (including any Carryover Amount remaining in the Health Care Flexible Spending Account from a prior Plan Year, as defined in Section 5.05) is more than the maximum amount that the Plan could require as payment for the remainder of that year to maintain Health Care Flexible Spending Account coverage (without regard to any Carryover Amount). For purposes determining the amount of the benefit under the Plan that the qualified beneficiary can become entitled to receive during the remainder of the Plan Year in which the qualifying event occurs, the Plan may deduct from the maximum benefit available to the qualified beneficiary any reimbursable claims submitted to the Plan before the date the qualifying event occurred. If a qualified beneficiary is not eligible for or fails to elect COBRA coverage, or fails to make required contributions for COBRA coverage, any unused balance, including any remaining Carryover Amount, is forfeited.

The qualified beneficiary is required to pay, in monthly installments, on an after-tax basis, up to 102% of the monthly amount of salary reductions being credited to his or her Health Care Flexible Spending Account (without regard to any Carryover Amount) immediately prior to the qualifying event for the continued coverage, as determined by the Plan Administrator.

If elected, coverage will continue until the earlier of (a) the last day of the Plan Year in which the qualifying event occurs or (b) the first day after the qualified beneficiary becomes (i) a covered employee or dependent under any other group health plan or (ii) entitled to Medicare. However, at the time COBRA continuation coverage is exhausted at the end of a Plan Year, a qualified beneficiary shall be permitted to carry over to the immediately following Plan Year a Carryover Amount. Such qualified beneficiary shall not be permitted to make additional contributions during such Plan Year or carry over any further amounts to any other Plan Year. Notwithstanding the foregoing, a qualified

beneficiary's coverage shall end and Carryover Amount forfeited upon the earlier of the following:

(i) The date on which the Plan Sponsor ceases to provide any group health plan to any employee; or

(ii) The date on which the qualified beneficiary fails to make required contributions.

This Section 5.06 is intended and shall be construed to satisfy the minimum requirements of COBRA, but not to create any rights in excess of such minimum requirements. The Plan Administrator shall adopt such rules for the administration of this Section 5.06 as it shall deem necessary and appropriate from time to time.

ARTICLE VI. HEALTH SAVINGS ACCOUNT

6.01 Health Savings Account Contributions

a. An HSA-Eligible Individual may elect to have a portion of his or her Compensation forwarded by the Company to an HSA established with one or more designated trustee(s) or custodian(s) (an "eligible HSA"), provided that the HSA-Eligible Individual has established his or her HSA as determined by the Plan Administrator. The Company reserves the right to designate in its discretion the trustee(s) or custodian(s) to which it shall forward HSA contributions. If a Covered Employee elects to contribute to an eligible HSA, the Covered Employee's Compensation will be reduced, and an amount equal to the reduction will be forwarded to the Covered Employee's HSA.

b. The Company may in its discretion contribute an amount to an HSA on behalf of an HSA-Eligible Individual who has established his or her HSA as determined by the Plan Administrator through the Plan, without regard to the comparability rules of Section 4980G of the Code. The Company reserves the right to change the amount or timing of such contributions at any time, and from time to time.

6.02 Maximum HSA Contribution Limits

An HSA-Eligible Individual's before-tax contributions, combined with the Company contributions, if any, made to the HSA-Eligible Individual's HSA under Section 6.01 are subject to the statutory maximum amount under Section 223(b) of the Code for the calendar year in which the contribution is made. Each HSA-Eligible Individual shall ensure that he or she does not elect contributions as described in Section 6.01 to the extent that the statutory maximum amount under Section 223(b) of the Code would be exceeded in a Plan year.

6.03 Recording Contributions for an HSA

As described in Section 6.05, the HSA coverage described herein is not an employer-sponsored employee benefit plan – it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Company, will establish and maintain the HSA. The Company may, however, limit the number of HSA providers to whom it will forward contributions that an Employee makes on a before-tax basis. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes on a before-tax basis, but it will not require a separate fund or otherwise segregate assets for this purpose.

6.04 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Section 223 of the Code.

6.05 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Contributions under the Plan consist solely of the ability to make contributions to the HSA on a before-tax basis and any discretionary Company contributions. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) for each HSA-Eligible Individual's HSA trust or custodial account will be provided by and are set forth in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing HSA-Eligible Individual and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. The Company has no authority or control over an HSA-Eligible Individual's use of the funds that have been deposited in an HSA. The HSA feature of the Plan under this Article VI is not subject to the continuation coverage requirements under part 6 of Title I of ERISA and Section 4980B(f)(2) of the Code. Even though this Plan may allow before-tax Employee contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Company. Distributions from a HSA-Eligible Individual's HSA (whether before or after termination of employment) and all other matters relating to a Covered Employee's HSA are outside of this Plan.

ARTICLE VII. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.01 Available Benefits

A Covered Employee who has elected to participate in the Dependent Care Flexible Spending Account shall be entitled to benefits thereunder to the extent specified in this Article VII. Benefits under the Dependent Care Flexible Spending Account portion of the Plan shall consist of reimbursement of Covered Dependent Care Expenses described in Section 7.02. A Covered Employee shall be entitled to reimbursement for covered dependent care expenses that he or she incurs during the Plan Year. The maximum benefits payable to any Covered Employee under the Dependent Care Flexible Spending Account for any Plan Year shall not exceed the lesser of (i) $5,000 ($2,500 in the case of a separate return filed by a married individual), or (ii) the earned income limitation described in Section 7.02 hereof. At any time, a Covered Employee's Covered Dependent Care Expenses may be reimbursed up to the credit balance in the Participant's Dependent Care Reimbursement Account at that time.

7.02 Covered Dependent Care Expenses

a. General Rule

Subject to the limits contained in Article IV and Section 7.01, expenses are "Covered Dependent Care Expenses" under this Plan if they are *employment-related* expenses that are:

(i) incurred by an Employee while he or she is a Covered Employee (an expense is incurred at the time the services to which the expenses relate are provided, not the date they are charged, billed, or paid); and

(ii) incurred for the care of a Qualifying Person or for related *household services* in order to enable the Covered Employee to be gainfully employed for any period for which there are one or more Qualifying Persons with respect to the Covered Employee.

Except as provided above, Covered Dependent Care Expenses do not include expenses incurred while a Covered Employee (or Spouse, if married) is off work for any reason, including illness or vacation. However, expenses incurred during certain "short" or "temporary" absences for illness or vacation may be eligible for reimbursement if the Covered Employee is required to pay for dependent care on a weekly or longer basis. Also, if the Covered Employee works part-time, he or she is not required to allocate expenses between time worked and time not worked if the Covered Employee is required to pay for care on a weekly or longer basis.

Employment-related means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, the expense must also enable the Covered employee's Spouse to be gainfully employed, actively seek gainful employment, or be a full-time student, unless the Spouse is physically or mentally disabled.

Household services means services ordinarily necessary to maintain a Covered employee's home and rendered as part of a Qualifying Person's *care*. *Care* for this purpose means services primarily to assure the well-being and protection of at least one Qualifying Person.

b. Dependent Care Centers

Covered Dependent Care Expenses also include employment-related expenses incurred for a dependent care center, as defined in Section 21 of the Code, which

(i) provides care for more than 6 individuals (other than individuals who reside at the facility),

(ii) receives a fee, payment or grant for the care provided for any of the individuals, and

(iii) complies with all the applicable laws and regulations of a State or unit of local government.

c. Services Outside the Household

Notwithstanding anything to the contrary contained in this Section 7.02, Covered Dependent Care Expenses do not include expenses incurred for services outside the Covered Employee's household for the care of a Qualifying Person described in Section 2.41(b) and (c), unless such Qualifying Person regularly spends at least 8 hours each day in the Covered Employee's household.

d. Payments to Related Individuals

Covered Dependent Care Expenses do not include amounts paid to the following individuals:

(i) an individual with respect to whom the Covered Employee or his/her Spouse is allowed a deduction for a personal exemption under Section 151(c) of the Code for the Plan Year, or

(ii) a child of the Covered Employee who is under age 19 at the close of the Plan Year.

e. Maximum Amount of Tax-Free Reimbursement

The maximum available amount of tax-free reimbursement under the Plan for any Covered Employee for Covered Dependent Care Expenses incurred during any Plan Year shall be the smallest of:

(i) the Covered Employee's earned income for the Plan Year; or

(ii) the actual or deemed earned income of the Covered Employee's spouse, if applicable, for the Plan Year if the Covered Employee is married on the last day of the Plan Year; or

(iii) $5,000 ($2,500 in the case of a married individual filing a separate federal income tax return); or

(iv) the portion of the Covered Employee's Salary Reduction Amount in his or her most recent validly filed Plan Election as allocated to the Dependent Care Flexible Spending Account under the Plan.

For this purpose, *earned income* shall be determined in accordance with Section 129(e)(2) of the Code. Generally, earned income is computed without considering community property laws and means wages, salaries, tips, and other compensation like strike benefits, disability pay reported as wages, and net earnings from self-employment, but does not include pensions, annuities, Social Security payments, workers' compensation, unemployment compensation or a nonresident alien's income not connected with United States business.

If the Covered Employee's Spouse is physically or mentally incapable of caring for himself or herself or is a full-time student for at least 5 months in a calendar year at an educational institution (as defined in Section 21(e) of the Code) for the number of hours that the institution considers to be a full-time course of study, he or she shall be deemed to have earned income of not less than $250 per month if the Covered Employee has one Qualifying Person, an $500 per month if the Covered Employee has two or more Qualifying Persons.

7.03 Ledger Accounts

a. Establishment of Ledger Accounts

The Company, the Plan Administrator, or the representative of the Plan Administrator shall establish and maintain on its books a ledger account for each Plan Year with respect to each Covered Employee in the Dependent Care Flexible Spending Account.

b. Credits to Ledger Accounts

The ledger account maintained on behalf of a Covered Employee with respect to the Dependent Care Flexible Spending Account shall be credited each payroll period during the Plan Year that a Covered Employee's Plan Election with respect to the Dependent Care Flexible Spending Account is in effect with an amount equal to a prorated portion of the amount designated by the Covered Employee in his or her Plan Election as allocated to the Dependent Care Flexible Spending Account for the Plan Year. Notwithstanding the foregoing, with respect to the Plan Year in which a Covered Employee is initially eligible to participate in the Dependent Care Flexible Spending Account, amounts (if any) of before-tax contributions that would have been contributed from such Covered Employee's Compensation in payroll periods after the Covered

Employee first became eligible but before such Covered Employee submitted his or her Plan Election to the Plan Administrator (or the representative of the Plan Administrator), as determined in the sole discretion of the Plan Administrator, shall not be credited to the Covered Employee's ledger account. Forfeitures reallocated in accordance with Section 7.04 also may be credited to the ledger accounts maintained for Covered Employees.

All amounts credited to each such ledger account shall be the property of the Company and shall not be made available to the Covered Employee unless and until paid out in accordance with Article VIII.

c. Debits to Ledger Accounts

Subject to Section 7.04, a Covered Employee's ledger account shall be debited from time to time by an amount, equal to any payment to or for the benefit of the Covered Employee with respect to whom it such ledger account was established, of Covered Dependent Care Expenses incurred by the Covered Employee in the Plan Year and claimed in a timely manner pursuant to Article VIII.

In no event shall the amount debited at any time for Covered Dependent Care Expenses incurred during a Plan Year exceed:

(i) the amount credited, in accordance with Section 7.03(b) and by operation of Section 7.04, to the Covered Employee's ledger account at the time such Covered Dependent Care Expenses are incurred, minus

(ii) the aggregate amount of Covered Dependent Care Expenses that have already been debited to such individual's ledger account for such Plan Year in accordance with this Article VII.

7.04 Forfeiture Provision

As of the last day of the Plan Year or as of any earlier date on which the Covered Employee terminates participation in the Dependent Care Flexible Spending Account, the Plan Administrator (or the representative of the Plan Administrator) shall determine whether the amount of Covered Dependent Care Expenses paid or payable to the Covered Employee for such Plan Year is less than the amount credited to the Covered Employee's ledger account for such Plan Year. Any remaining amount credited to the ledger account maintained on behalf of the Covered Employee as of such date after processing all timely and valid claims submitted in accordance with Article VIII shall be forfeited and Covered Employees may not cash out such forfeitures or apply them toward other Plan benefits.

Notwithstanding the previous sentence,

a. A Covered Employee shall be entitled to submit, after the close of the Plan Year but no later than March 31 of the following calendar year, claims for reimbursement out of any remaining amounts credited to his or her ledger account attributable to the Plan Year in which the expenses were incurred, and such remaining credited amount shall not be forfeited until the date such limited period ends; and

b. If the Dependent Care Flexible Spending Accounts of Covered Employees have an experience gain with respect to a Plan Year, the excess of credited amounts and income over total claim reimbursements and administrative costs may, at the discretion of the Plan Administrator (or the representative of the Plan Administrator), be used to cover the administrative expense of the Plan, be used to reduce required contributions for the following Plan Year, be returned on a reasonable and uniform basis to Covered Employee, or be used as otherwise permitted under Section 125 of the Code and the regulations issued thereunder. Experience gains may not be allocated to Covered Employees based on their individual claims experience.

7.05 Statement of Expenses

In accordance with Section 129(d)(7) of the Code, the Plan Administrator (or the representative of the Plan Administrator) shall furnish, on or before January 31, a written statement to each Employee who was a Covered Employee in the immediately preceding Plan Year of the amounts paid or expenses incurred by the Company in providing dependent care assistance under the Plan to such Employee.

ARTICLE VIII. CLAIMS AND APPEALS

8.01 Claims Procedures

a. General Rule

The Plan Administrator shall establish reasonable procedures pursuant to which a Covered Employee or Covered Dependent (each, a "Claimant" for purposes of benefit claims under this Article VIII) may make a claim for benefits under the Plan and appeal any Adverse Benefit Determination resulting from such a claim. Claims determinations shall be made by the Claims Administrator named in the applicable Covered Benefit Document, under the reasonable claims procedures for each Covered Benefit set forth in the applicable Covered Benefit Document. All such separate claims procedures shall operate within the time periods and other guidelines set forth in this Article VIII, U.S. Department of Labor regulations under Section 503 of ERISA, and, in the case of a Medical Plan option that is subject to the "market reform" provisions of PPACA, the internal and external review requirements and any related regulations or guidance issued thereunder. If no separate claims procedure governs the disposition of a claim or dispute under a Covered Benefit, then the claims procedures described in this Article VIII shall govern.

b. Authority to Decide Claims

Except to the extent otherwise required by law, all claims for benefits shall be governed by the procedures set forth the applicable underlying Covered Benefit Document. All claims for benefits under the Plan shall be submitted to and decided by such Claims Administrator as the Plan Administrator may from time to time designate, in the form and within the time specified by the Plan Administrator. The Plan Administrator may delegate its authority and responsibilities under this Article to a Claims Administrator, provided such delegation is in writing. Any reference to Plan Administrator in this Article shall mean the applicable Claims Administrator if the relevant authority and responsibility has been delegated by the Plan Administrator to that Claims Administrator. The Plan Administrator has sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall be paid only if the Plan Administrator decides in its sole discretion that the Claimant is entitled to them. The Plan Administrator's decisions made pursuant to this Section are intended to be final and binding on Covered Employees, Covered Dependents and others.

To the extent that an insurance company (or other entity) administers claims under a Covered Benefit, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such insurance company (or other entity). In such case, the insurance company (or other entity) shall be a "named fiduciary" for purposes of such Covered Benefit, as permitted under Department of Labor Regulations Section 2560.503-1(g).

c. Non-Benefit Claims

Any claim or dispute that is not a claim for benefits under Section 503 of ERISA, including claims or disputes involving eligibility (including denial of continuation coverage rights based on gross misconduct exception), enrollment and election changes (a "non-benefit claim"), shall be reviewed by the Plan Administrator (or its delegate) in accordance with the following procedures:

(i) Human Resources Personnel will respond to the Covered Employee (or Covered Dependent) within 60 days after receipt of a non-benefit claim.

(ii) If the claim is denied (in whole or in part), the Covered Employee (or Covered Dependent) will be advised of the decision and informed of his or her right to appeal to the Plan Administrator.

(iii) The Covered Employee (or Covered Dependent) may appeal the denial by filing a written request with the Plan Administrator within 180 days after he or she is advised of the claim denial.

(iv) If the claim denial is appealed, the Plan Administrator will render a decision on appeal within 30 days after receipt of the claim.

(v) If the Plan Administrator denies the claim (in whole or in part), the Plan Administrator will provide the Covered Employee (or Covered Dependent) with written notice describing the reason for the denial. The Plan Administrator's decision is final and cannot be appealed under the Plan.

d. Claims for Non-ERISA Covered Benefits

Claims and appeals under any Covered Benefit not subject to ERISA, including the Dependent Care Flexible Spending Account, will be reviewed by the Plan Administrator (or its delegate) and decided in a uniform and non-discriminatory manner. Claims under a Covered Benefit not subject to ERISA must be appealed, in writing, within 60 days of the date the Claimant receives the denial notice.

e. Exhaustion of Administrative Remedies

Claimants shall not be entitled to challenge the Plan Administrator’s or Claims Administrator’s determinations in judicial or administrative proceeds without first complying with the administrative internal claims and appeals procedures set forth in the applicable Covered Benefit Document or under this Article, as appropriate, within the applicable time limit based on the type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party.

8.02 Payment Procedures

a. Payment of Claim

Benefits shall be payable to the Claimant upon establishment of the right thereto, however:

(i) the Claims Administrator may, in its discretion, make payment directly to the institution, provider, individual, or entity that renders medical care or service, or to a person or entity that has provided or paid for, or agreed to pay for, any benefits payable under the Plan. No payment by the Plan pursuant to this paragraph shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical services or supplies except to the extent that the Plan actually chooses to do so. The Plan reserves the right to make payment directly to the Covered Employee;

(ii) if a Claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Claims Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such Claimant as the Claims Administrator deems appropriate;

(iii) to the extent required by Section 609(a) of ERISA, the Plan will pay benefits in accordance with any assignment of rights made by or on behalf of a Covered Employee as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act; and

(iv) payment of benefits pursuant as provided in this Article VIII shall discharge the Plan, the Plan Administrator and the representatives of the Plan Administrator from any further liability therefor.

To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Employee to such payment for such items or services.

b. Facility of Payment

If a Claimant dies before all amounts payable under the Plan have been paid, or if the Claims Administrator determines that the Claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the Claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the Claimant may be paid to any other person or institution determined by the Claims Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

c. Unclaimed Self-Funded Plan Funds

Except as otherwise specified in the Covered Benefit Document for a particular Covered Benefit, in the event that a benefits check issued by the Claims Administrator or Plan Administrator under a self-funded Covered Benefit remains uncashed after one year, the check will be voided and the funds will be returned to the Covered Benefit to be applied to the payment of current benefits and administrative fees under the Covered Benefit. In the event that the Covered Employee or Covered Dependent (or the beneficiary as defined under ERISA) subsequently requests payment with respect to the voided check, the Claims Administrator or Plan Administrator for the applicable Covered Benefit will make such payment under the terms and conditions of that Covered Benefit as in effect when the claim was originally presented.

d. Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future Plan payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

e. Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

f. Misrepresentation or Fraud

A Covered Employee who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator (or the representative of the Plan Administrator) shall decide such matters on a case by case basis. A Covered Person who submits a fraudulent claim under the Plan or who otherwise willfully and knowingly engages in an activity intended to defraud the Plan also will be subject to such disciplinary action, including but not limited to termination of employment and prosecution, as the Company, in its discretion, may impose.

g. Third Party Recovery/Reimbursement

The Plan's right of recovery in third-party actions shall be determined in accordance with the following provisions, to the extent not inconsistent with the provisions of any applicable insurance contract, in which case the provisions of the insurance contract shall control.

(i) In General

When a Covered Employee or Covered Dependent receives Plan benefits that are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist Plan, any no fault or school insurance Plan, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Covered Employee shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Covered Employee recovers from any third party.

(ii) Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Employee or Covered Dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right is regardless of the manner in which the recovery is structured or worded, even if the Covered Employee or Covered Dependent has not been paid or fully reimbursed for all of his or her damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Covered Employee or Covered Dependent to assert a claim to any of the benefits to which the Covered Employee or a Covered Dependent may be entitled. The Plan will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Covered Employee or Covered Dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Covered Employee and Covered Dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Covered Employee or Covered Dependents.

(iii) Covered Employee Duties and Actions

By participating in the Plan each Covered Employee and Covered Dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by

agreement, each Covered Employee and Covered Dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Covered Employee or Covered Dependent has any reason to believe that he or she may be entitled to recovery from any third party, the Covered Employee or Covered Dependent must notify the Plan. And, at that time, the Covered Employee or Covered Dependent (and his or her attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation/reimbursement rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Covered Employee or Covered Dependent to any payment, amount or recovery from a third party.

If a Covered Employee or Covered Dependent fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Covered Employee or Covered Dependent until the agreement is signed. Alternatively, if a Covered Employee fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Employee or a Dependent, the Covered Employee's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Covered Employee and Covered Dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

8.03 Estoppel of Participants

The Plan Administrator (or the representative of the Plan Administrator) may rely upon any certificate, statement or other representation made to him or in respect of the Plan by any Covered Employee with respect to any fact required to be determined under any of the provisions of the Plan, and will not be liable on account of the payment of any moneys or the doing of any act in reliance upon any such certificate, statement or other representation. In the discretion of the Plan Administrator (or the representative of the Plan Administrator), any such certificate, statement or other representation will be conclusively binding upon the Covered Employee, and such Covered Employee will thereafter and forever be estopped from, disputing the truth and correctness of such certificate, statement or other representation.

8.04 Legal Action

Before pursuing a legal remedy, a claimant shall first exhaust all claims and appeals procedures required by the Plan. No action at law or in equity shall be brought to recover benefits under the Plan prior to the expiration of 180 days after a properly completed claim form has been filed in accordance with the requirements set forth in this Article VIII. Furthermore, no action shall be filed in a court or before an agency for the payment

of benefits under the Plan unless the review procedures set forth in this Article VIII are exhausted. A claimant may bring an action in connection with the Plan only in the United States District Court for 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 such a suit may be initiated.

8.05 Coordination of Benefits

a. In General.

This Plan contains a provision coordinating it with other group medical plans under which a Participant is covered so that the Participant receives all of the benefits to which he is entitled, but not to exceed 100% of total allowable expenses. If an individual claiming benefits under the Plan and/or any Covered Benefit is covered under two or more plans (including the Plan and/or a Covered Benefit), the order in which benefits shall be determined is as set forth in the applicable SPD. To the extent that the applicable Covered Benefit Document does not set forth rules regarding benefit coordination for the Covered Benefit, the terms of this Section shall apply; provided, however, that the coordination of benefits provision does not apply under the Plan for outpatient prescription medications. Therefore, this Plan will not coordinate benefits when a member has primary coverage under another plan for outpatient prescription medications.

(i) An "allowable" expense is any necessary, reasonable expense covered, at least in part, by one of the plans and not otherwise excluded from coverage.

(ii) "Other group medical plans" mean the following types of medical, dental, and vision care benefits:

(A) coverage under a governmental program or provided or required by law, except a state Medicaid plan under Title XIX of the Social Security Act;

(B) group health insurance or group type coverage whether insured or uninsured. This includes group or group type coverage under health maintenance organizations and other prepayment, group practice or individual practice coverage; and

(C) group-type contracts, which are contracts not available to the general public and which can be obtained and maintained only because of membership in or in connection with a particular organization or group; and

(D) medical benefits coverage and group, group-type, and individual automobile coverage including "no fault" coverage, medical coverage, and uninsured or underinsured motorist coverage and traditional automobile "fault" type contracts.

Each such contract or other arrangement is a separate group medical plan. If an arrangement has two parts and coordination of benefit rules apply only to one of the two, each of the parts is a separate group medical plan.

(iii) When a claim is made, the "primary" plan pays its benefits without regard to any other plans. The "secondary" plans adjust their benefits so that the total benefits available will not exceed allowable expenses. No plan pays more than it would without the coordination provision.

b. Order of Benefit Coordination.

(i) A plan that does not have a coordination of benefits provision will always be deemed to have primary benefit payment responsibility.

(ii) When both plans have a coordination of benefits provision, the plan covering the individual other than as a dependent (*e.g.*, employee, member, retiree) will have primary payment responsibility, and the plan covering the individual as a dependent will have secondary payment responsibility.

(iii) With respect to coverage of an eligible dependent child, if the child's parents are neither legally separated nor divorced, the plan of the parent whose birthday falls earlier in the year will have primary payment responsibility, and the plan of the parent whose birthday falls later in the year will have secondary payment responsibility. If both parents have the same birthday then the plan of the parent who has been covered longer will have primary payment responsibility.

(iv) With respect to coverage of an eligible dependent child, if the child's parents are either legally separated (whether or not ever married) or divorced, the plan of the parent having custody of the child will have primary payment responsibility, the plan of the spouse of the parent having custody of the child will have secondary payment responsibility, the plan of the parent not having custody will have tertiary payment responsibility, and the plan of the spouse of the parent not having custody will have final payment responsibility. However, if there is a court decree specifying the responsibility for coverage of the child, then the plan of the parent having such responsibility will have primary payment responsibility.

(v) A plan that covers the individual as an active employee who is neither laid off nor retired (or as a dependent of an active employee) will have primary payment responsibility, and a plan that covers the individual as an inactive employee (or as a dependent of an inactive employee) will have secondary payment responsibility. However, if one plan does not have this rule and the plans do not agree on the order of benefits, then this rule will not apply.

(vi) If an individual is covered under COBRA coverage or state continuation coverage, the plan covering the individual as an employee, member or retiree (or as the dependent of an employee, member or retiree) will have primary payment responsibility, and the continuation coverage will have secondary payment responsibility. This rule will apply only when both plans provide non-dependent

coverage to the individual, or when both plans provide dependent coverage to the individual. If one plan provides dependent coverage and the other plan provides non-dependent coverage, the rule described in subsection (ii) above will apply.

(vii) If none of the above rules will serve to determine the order of payment of a claim, the plan that has covered the individual the longest will have primary payment responsibility.

c. Coordination of Benefits with Medicare.

(i) Each Medicare-eligible Covered Employee shall continue to be covered by the Plan unless he or she elects not to be covered by the Plan and to instead enroll in Medicare as his or her primary coverage. In such event, the Plan Administrator shall notify such Covered Employee that the Plan will not be permitted to provide or pay for any secondary benefits.

(ii) Each Medicare-eligible Covered Dependent shall continue to be covered by the Plan unless he or she elects not to be covered by the Plan and to instead enroll in Medicare as his or her primary coverage.

(iii) Notwithstanding anything in Sections 8.05(a) or (b) to the contrary, Medicare shall be the primary coverage for:

(A) a Covered Employee or Covered Dependent who is entitled to disability benefits under Section 226(b) of the Social Security Act, provided that such individual's coverage under the Plan is not by virtue of current employment status; and

(B) a Covered Employee or Covered Dependent with end stage renal disease ("ESRD") who is entitled to or eligible for benefits under Section 226A of the Social Security Act after the thirty (30) month period beginning with (i) the first month in which the individual became entitled to benefits under Section 226A of the Social Security Act, or (ii) the first month in which the individual became eligible for such benefits on the basis of ESRD, regardless of whether he or she applied for such benefits.

ARTICLE IX. SPECIAL COVERAGE PROVISIONS

9.01 COBRA Continuation Coverage

This section shall only apply to a Covered Benefit that is considered a "group health plan" under Code Section 5000(b)(1). All Covered Benefits subject to the "continuation coverage" requirements of COBRA will be administered in accordance with the rules set forth in this Section, which are intended to satisfy the requirements of Section 4980B of the Code, Part 6 of Subtitle B of Title I of ERISA, and any related regulations.

a. Qualifying Events.

A Covered Employee or Covered Dependent who would otherwise lose group health plan coverage as a result of a "qualifying event," as defined below, shall be entitled to elect continuation of group health plan coverage under the Covered Benefit as provided by COBRA. The coverage shall be identical to the coverage provided persons to whom a qualifying event has not occurred. A "qualifying event" is any of the following:

(i) termination as an Employee (other than for gross misconduct, as determined by the Plan Administrator in its sole discretion) or reduction of hours worked so as to render the Covered Employee or Covered Dependent ineligible for group health plan coverage under a Covered Benefit;

(ii) the Covered Employee's death;

(iii) divorce of the Covered Employee from his Spouse, or termination of a Civil Union or Domestic Partnership;

(iv) for a Covered Dependent, loss of coverage due to the Covered Employee becoming entitled to Medicare;

(v) for a Dependent child, ceasing to qualify as an eligible Dependent under the applicable Covered Benefit; or

(vi) a proceeding involving the Company under Title 11 of the United States Code, with respect to a retired Employee. For purposes of this subparagraph, a loss of coverage shall include a substantial elimination of coverage with respect to a Covered Employee or Covered Dependent described in Section 4980F(g)(1)(D) of the Code within one year before or after the date of commencement of such proceeding.

b. Notice to Plan Administrator.

(i) A Covered Employee or Covered Dependent must notify the Plan Administrator in writing within sixty (60) days after a divorce or legal separation or after an eligible Dependent child ceases to qualify as an eligible Dependent under the applicable Covered Benefit. All rights to continued coverage under a Covered Benefit

shall be lost by the failure to timely give this required written notice to the Plan Administrator.

(ii) An eligible Covered Employee may elect COBRA continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with such Covered Employee while the Covered Employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the Covered Employee has notified the Plan Administrator in writing within thirty (30) days of the child's birth, adoption or placement for adoption.

(iii) The Company is requires to notify the Plan Administrator of the following qualifying events within thirty (30) days of the event:

(A) the Covered Employee's death;

(B) termination or reduction in hours that the Covered Employee works; or

(C) the Covered Employee becoming entitled to Medicare.

c. Notice to Participant.

(i) The Plan Administrator must, prior to the later of fourteen (14) days of being notified of a qualifying event or forty-four (44) days after occurrence of such event, advise the Covered Employee and his or her Covered Dependent of the right to continue coverage.

(ii) Notice of the right to continued coverage to a Spouse, Civil Union Partner, or Domestic Partner will be deemed notice to any Dependent children residing with the Spouse, Civil Union Partner, or Domestic Partner. An election to receive or to waive coverage for a Dependent child may be made by the Covered Employee or his or her Spouse, Civil Union Partner, or Domestic Partner with whom the Dependent child resides.

d. Election of Coverage.

If the Covered Employee or his or her Covered Dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost. Coverage must be elected within sixty (60) days of the latest of the following:

(i) the date the Covered Employee or his or her Covered Dependent(s) would lose coverage due to a qualifying event (as defined above); or

(ii) the date the Covered Employee or Covered Dependent is advised by the Plan Administrator of the right to continued coverage.

e. Payment for Coverage.

(i) The Covered Employee and Covered Dependent may be required to pay up to 102% of the group rate for the continued coverage as determined by the Plan Administrator on an after-tax basis and have the option to make these payments in monthly installments. A thirty (30) day grace period of payment of group rates will also apply to coverage being continued. Contribution amounts and benefits for continuation coverage are subject to change. The Covered Employee will be notified of any changes in contribution amounts or benefits available under the applicable Covered Benefit.

(ii) The Covered Benefit will not be required to bill covered individuals for continuation coverage. If any payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Covered Benefit will terminate and will not be reinstated.

(iii) If the Covered Employee or Covered Dependent elects continuation of coverage after the qualifying event, then the Covered Employee or Covered Dependent will have forty-five (45) days from the date of election to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost due to the qualifying event at least through the date of payment. There is no grace period for the first payment.

f. Period of Coverage.

(i) If elected, the maximum period for continued coverage for a qualifying event involving termination of employment or reduced working hours is eighteen (18) months. If the Covered Employee or Covered Dependent is found by the Social Security Administration to have been disabled at any time during the first sixty (60) days of continuation coverage (regardless of when the disability commenced), then the disabled person and his covered family members will be eligible for up to twenty-nine (29) months of continued coverage (an additional eleven (11) months). To be eligible for that additional coverage, the disabled person must remain disabled and must notify the Plan Administrator within 60 days after the later of the disability determination by the Social Security Administration, the date of the qualifying event, or the date of the loss of coverage, and before the end of the original eighteen (18) month coverage period. An increased charge of up to 150% of the cost of covered under the Covered Benefit may be required for the eleven (11) extra months of coverage. The disabled person must promptly notify the Plan Administrator of any Social Security Administration finding that he is no longer disabled.

(ii) If a second qualifying event occurs within the applicable eighteen (18) or twenty-nine (29) month period, the period of coverage may be extended up to thirty-six (36) months from the date of the first qualifying event.

(iii) For all other qualifying events, the maximum period of continued coverage is thirty-six (36) months.

(iv) Other events shall cause continued coverage to end sooner. Coverage will end short of the maximum period on the earliest of the following:

(A) the date the Company ceases to provide any group health plan to any employee;

(B) the date the Covered Employee or Covered Dependent fails to make any required installment contribution payment;

(C) the date that there has been a final determination by the Social Security Administration that the Covered Employee or Covered Dependent who has elected to extend coverage for up to twenty-nine (29) months due to disability is no longer disabled; or

(D) the first day after the Covered Employee or Covered Dependent makes a COBRA election, on which the Covered Employee or Covered Dependent becomes:

(1) a covered employee or dependent under any other group health plan; or

(2) in the case of a Covered Employee or Covered Dependent who is not described in Section 4980F(g)(1)(D) of the Code, entitled to Medicare.

However, if the Covered Employee or Covered Dependent becomes covered by another group health plan and has a preexisting condition which is not covered by that other plan, then COBRA coverage (at least for that preexisting condition) will not be terminated due to such other coverage.

g. Health Care Flexible Spending Account. A Covered Employee or Covered Dependent who would otherwise lose coverage under the Health Care Flexible Spending Account as a result of a qualifying event shall be permitted to continue coverage under the Health Care Flexible Spending Account, provided that as of the date of the qualifying event, the maximum benefit available for the rest of the Plan Year (including any Carryover Amount from a prior Plan Year) is more than the maximum amount that the Plan could require as payment for the remainder of that year to maintain Health Care Flexible Spending Account coverage. Applicable premiums will be paid monthly on an after-tax basis. The election shall be made in accordance with procedures established by the Plan Administrator. Notwithstanding any provision in the Plan to the contrary, COBRA continuation coverage as provided in this Section 9.01 will continue only until the earlier of (i) the last day of the Plan Year in which the qualifying event occurs or (ii) the first day after the Covered Employee or Covered Dependent becomes (A) a covered employee or dependent under any other group health plan or (B) entitled to Medicare; provided, however, at the time COBRA coverage ends, the Covered Employee or Covered Dependent shall be permitted to carry over to the immediately following Plan Year a Carryover Amount, but he or she shall not be permitted to make additional contributions during such Plan Year or carry over any further amounts to any other Plan Year.

h. Continuation coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation coverage retroactively if the individual is determined to be ineligible for continuation coverage. The Plan Administrator intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements. This Section shall not create any rights in excess of the minimum required by law.

9.02 Family and Medical Leave

All Covered Benefits subject to the "maintenance of health benefits" provisions of the FMLA, as amended, will be administered in accordance with the FMLA, any related regulations, and the administrative rules established by the Plan Administrator.

9.03 USERRA

All Covered Benefits subject to the "continuation coverage" requirements of USERRA, as amended, will be administered in accordance with USERRA, any related regulations, and the administrative rules established by the Plan Administrator.

9.04 HIPAA

All Covered Benefits subject to the "portability" provisions of HIPAA, as amended, will be administered in accordance with HIPAA's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

9.05 Maternity-Related Benefits

All Covered Benefits subject to the provisions of the Newborns' and Mothers' Health Protection Act will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

9.06 Mental Health Benefits

All Covered Benefits subject to the "parity" requirements of the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act of 2008 will be administered in accordance with those Acts' provisions, any related regulations, and the administrative rules established by the Plan Administrator.

9.07 Benefits for Reconstructive Surgery Following a Mastectomy

All Covered Benefits subject to the provisions of the Women's Health and Cancer Rights Act under Section 713 of ERISA will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

9.08 Use of Genetic Information

All Covered Benefits subject to the "health insurance" provisions of the Genetic Information Nondiscrimination Act of 2008 ("GINA") will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

9.09 Health Care Reform

All Covered Benefits subject to the "market reform" provisions of PPACA, as amended, will be administered in accordance with PPACA, any related regulations, and the administrative rules established by the Plan Administrator.

9.10 Medicaid Eligibility

As required by Section 609(b) of ERISA, if a Covered Employee or Covered Dependent is eligible for, or receives, medical assistance under a state plan for medical assistance approved under Title XIX of the federal Social Security Act (Medicaid), any Covered Benefit subject to Section 609(b) of ERISA shall not take such eligibility or provision of benefits into account in enrolling such an individual in any such Covered Benefit or paying for benefits for such an individual under any such Covered Benefit. Further, payment for benefits under any Covered Benefit subject to Section 609(b) of ERISA for such individual shall be made in accordance with any assignment of rights made by or on behalf of such an individual as required by a state plan for medical assistance approved under Title XIX of the federal Social Security Act pursuant to Section 1912(a)(1)(A) of the Act (as in effect on August 10, 1993). Finally, to the extent payment has been made under Medicaid for any such individual for benefits payable under any Covered Benefit subject to Section 609(b) of ERISA, payment for such benefits under any such Covered Benefit shall be made in accordance with any state law that provides that the state has acquired the rights with respect to such individual to such payment for such benefits.

9.11 Conversion of Coverage

Unless an insurance contract or SPD provides otherwise, the Plan will not provide conversion coverage; provided, however, that nothing in a Covered Benefit will preclude a Covered Employee from exercising any conversion option made available to him or her by an insurance company under an insurance company contract. Unless an insurance contract or SPD provides otherwise, neither the Plan Administrator nor the Company will have any obligation to provide notice of any such conversion option.

9.12 Health Management Plans

Subject to the terms and conditions of the Plan and the Medical Plan, Covered Employees may be entitled to benefits with respect to services or supplies received pursuant to the terms of health promotion and wellness initiatives established and implemented by the Company, with such service providers as the Plan Sponsor deems appropriate (referred to herein as "Health Management Plans"). The Health Management Plans are designed to provide Covered Employees with enhanced benefits to aid in the prevention and treatment of health-related problems and to provide "medical care" (as defined in Section

733 of ERISA). Such other wellness or general health promotion programs that the Company may establish for Employees and their dependents that do not provide "medical care" shall not be a part of or subject to the terms of this Plan.

a. All contracts and other agreements between the Company and the service providers for any Health Management Plan are incorporated as part of the Plan by this reference, except to the extent any contract or agreement with a service provider is inconsistent with the terms of the Plan. The Plan Administrator will provide Covered Employees with descriptions of the Health Management Plans established and implemented under the Plan in separate communication materials from time to time.

b. To the extent applicable and required for any particular Health Management Plan, such Health Management Plan shall be administered in compliance with ERISA, the Code, HIPAA, Title I of GINA, the Americans with Disabilities Act, PPACA and any regulations or guidance issued thereunder with respect to wellness or health promotion programs.

9.13 Certificates of Creditable Coverage

Until December 31, 2014 (or such other applicability date that develops through regulations or other sub-regulatory guidance), the Plan Administrator for each HIPAA Program shall provide to each Covered Employee or Covered Dependent who loses coverage under the Plan a certificate described in Section 701(e) of ERISA setting forth his or her period of creditable coverage (as defined in Section 701(c)(1) of ERISA) under the Plan.

a. Such certificate shall be provided automatically within the following timeframes:

(i) for an individual who is entitled to elect COBRA continuation coverage, no later than when a notice is required to be provided for a qualifying event;

(ii) for an individual who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and

(iii) for an individual who has elected COBRA continuation coverage, within a reasonable time after cessation of COBRA continuation coverage or, if applicable, after the expiration of any grace period for the payment of contributions.

b. The Plan Administrator will not issue an automatic certificate of creditable coverage for a Covered Dependent until the Plan Administrator has reason to know that the Covered Dependent has lost coverage under the Plan.

c. A certificate of creditable coverage will be provided upon request, if the request is made in writing to the Plan Administrator within 24 months after the individual loses coverage under the Plan. In that case, the certificate of creditable coverage will be provided at the earliest time that the Plan Administrator, acting in a reasonable and prompt fashion, can furnish it.

A “HIPAA Program” means a benefit program subject to the portability and administrative simplification requirements of HIPAA, as required by Section 9801(f) of the Code.

ARTICLE X. CONTRIBUTIONS, FUNDING AND PLAN ASSETS

10.01 Insuring and Funding Benefits.

Funding for the Plan will consist of an aggregation of the funding for all Covered Benefits and may include funding through insurance contracts, through the general assets of the Employer, through a trust, through Covered Employees' contributions, or through any combination thereof. The Employer will have the right to insure any benefits under the Plan or to establish any fund or trust for the payment of benefits under the Plan either as mandated by law or as the Employer deems advisable. If any benefit is funded by the purchase of insurance, the benefit will be payable solely by the insurer. To the extent funds are transferred to a trust to provide any benefit, that benefit will be payable from the assets of such trust. The Plan Sponsor will not have any further responsibility to pay such benefit. Anything in the Plan or a Covered Benefit Document to the contrary notwithstanding, no funding arrangement that is established to provide for a specific Covered Benefit shall be used to provide benefits under any other Covered Benefit.

10.02 Participant Contributions.

The Plan Administrator will determine whether any of the Covered Benefits will require Covered Employees to contribute toward the cost of coverage. Any Covered Benefits that require Employee contributions will be designated as optional Covered Benefits. The Plan Administrator will establish the cost of coverage applicable to Covered Employees under the optional Covered Benefits, may adjust such costs from time to time, and will determine whether such costs are to be paid by Employees and their Dependents on a pre-tax or an after-tax basis. A participant who is an Employee will be required to contribute such cost of coverage under the optional Covered Benefits elected under the Plan by automatic reduction of the participant's Compensation on a pre-tax or after-tax basis, as applicable. The Employer will track the participant contributions and apply them toward the cost of coverage of the optional Covered Benefit.

ARTICLE XI. ADMINISTRATION

11.01 Plan Administrator

The Board of Trustees reserves the power to appoint and remove the Company or a person, entity or committee to serve as Plan Administrator. The Board of Trustees has delegated its discretionary responsibilities with respect to the administration of the Plan to the Pension and Investment Subcommittee of the Finance Committee of the Board of Trustees of Meridian. The Pension and Investment Subcommittee of the Finance Committee of the Board of Trustees of Meridian has delegated its discretionary responsibilities with respect to the administration of the Plan to the Senior Vice President of Human Resources to administer the Plan.

11.02 Powers and Duties of Plan Administrator

The Plan Administrator (or a representative of the Plan Administrator) shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. In carrying out its functions under the Plan, the Plan Administrator shall have full power and discretionary authority to:

a. enforce, administer, construe, and interpret the provisions of the Plan;

b. adopt such rules and regulations with regard to the administration of the Plan, consistent with the terms of the Plan, that the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

c. determine the terms and provision of the elections, designations, consents, authorizations, and any other instruments to be executed and delivered by Employees as a condition of enrollment, receipt of benefits, or in order to exercise any rights under the Plan;

d. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

e. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

f. determine questions of fact and law arising under this Plan, including the right of any person to participate in, be covered by, or receive benefits from the Plan and the amount of such benefits; to inform the Company or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan (to the extent authority to determine claims has not been delegated to a separate Claims Administrator with respect to a given Covered Benefit); and to provide a full and

fair review to any individual whose claim for benefits has been denied in whole or in part;

g. engage the services of such person(s) or entity(ies) as it deems reasonably necessary or appropriate in connection with the administration of the Plan, including auditors, accountants, and legal counsel, who may be auditors, accountants, or legal counsel for the Company, and such other consultants and advisors, and make use of such agents and clerical personnel, as it shall deem advisable;

h. pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other consideration payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator (or the representative of the Plan Administrator);

i. delegate to other person(s) any responsibilities with respect to the Plan Administrator's functions hereunder, including without limitation those matters involving the exercise of discretion, provided however that such delegation shall be subject to revocation at any time by the Plan Administrator or at the direction of the Board of Trustees;

j. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

k. take all actions and make all decisions necessary or proper to carry out its responsibilities under the Plan.

11.03 Finality of Decisions

All decisions and determinations of the Plan Administrator (or a representative of the Plan Administrator) with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

11.04 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Company. Unless otherwise determined by the Company unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

11.05 Expenses

All expenses of the Plan shall be paid from Employee contributions or by the Plan, unless otherwise paid by the Company. The Company may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

11.06 Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties and/or to insure any Employee performing any administrative or ministerial function under the Plan.

11.07 Parties' Reliance

The Board of Trustees, the Company, the Plan Administrator, and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, certification, report, table, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs and upon any information supplied by a third party claims administrator. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Board of Trustees, the Company or its employees, except for willful misconduct or willful breach of duty to the Plan.

11.08 Plan Records

The Plan Administrator shall cause to be maintained such records and accounts as may be reasonably necessary or desirable for the proper management and administration of the Plan, shall render such statements to the Board of Trustees of the Company or its delegate(s) as the Board of Trustees may request, and shall report to the Board of Trustees no less frequently than annually with regard to the matters for which it is responsible hereunder.

11.09 Medical Child Support Orders

In the event the Plan Administrator receives a medical child support order (within the meaning of Section 609(a)(2)(B) of ERISA), the Plan Administrator shall notify the affected Covered Employee and any alternate recipient identified in the order of the receipt of the order and shall provide the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of Section 609(a)(2)(A) of ERISA). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Covered Employee and alternate recipient of such determination.

11.10 Decisions on Health Care

The Medical Plan, Dental Plan and Vision Plan hereunder provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of the Covered Employee and his or her Covered Dependents in

consultation with the health care providers selected by the individual. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement under the Plan. Any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense, may be disputed by the covered individual in accordance with the applicable claims procedure under the Plan. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the Company shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of benefits.

11.11 Inspection of Documents

The Plan document, SPDs and insurance contracts applicable to the underlying Covered Benefits will be available for inspection during normal business hours at the Human Resources Office of the Plan Sponsor or other reasonable location designated by the Plan Administrator.

ARTICLE XII. AMENDMENT, TERMINATION OR MERGER OF PLAN

12.01 Right to Amend the Plan

The Plan Sponsor reserves the discretionary right to modify or amend the Plan, including any Exhibit hereto, in any respect, at any time and from time to time, retroactively or otherwise, by written instrument adopted by the Board of Trustees of Meridian Health ("Board") or its designee and duly executed on behalf of the Plan Sponsor.

Notwithstanding the foregoing, the Board has delegated to the Pension and Investment Subcommittee of the Finance Committee of the Board of Trustees of Meridian Health ("Subcommittee") its authority under the Plan to amend the Plan or one or more Covered Benefits, by a written instrument or through the issuance of a revised summary plan description (or a summary of material modifications) to the extent that such amendment (i) is necessary or appropriate for such Plan, or Covered Benefit under the Plan to remain in compliance with applicable laws or regulations, (ii) will not increase the annual cost of the Plan or a Covered Benefit by more than $1,000,000, or (iii) is intended only to implement transactions approved by the Board or its designee.

In addition, the Subcommittee has delegated to the Senior Vice President of Human Resources its authority to amend the Plan or one or more Covered Benefits hereunder by a written instrument or through the issuance of a revised summary plan description (or a summary of material modifications). Notwithstanding any provision of the Plan to the contrary, the Plan Administrator or his or her delegate is authorized and directed to modify Exhibit A, and Exhibit B provided the requirements of Article XIII have been met, from time to time as needed without a formal amendment to the Plan document.

However, in no event shall a Plan amendment be valid that would cause the Plan to fail any applicable qualification requirements of Code Sections 79, 105, or 125, or any successors thereto, to the extent such statutes apply to the Plan.

12.02 Right to Terminate or Merge the Plan

Although the Plan has been established with the intention that it be maintained indefinitely, the Company (or its duly authorized representative) reserves, except as expressly provided in any applicable collective bargaining agreement, the unlimited right to terminate or merge the Plan at any time and without prior notice to any Covered Employee by written action of the Board of Trustees or its delegate.

The Company also reserves the right to withdraw any authority delegated hereunder and/or to delegate such authority to other persons or entities.

12.03 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company (or its duly authorized representative) shall determine except that no amendment, termination or merger shall reduce benefits payable for covered expenses

incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

ARTICLE XIII. ADOPTION OF THE PLAN OR WITHDRAWAL FROM THE PLAN

13.01 Adoption of Plan by Subsidiary or Affiliate

The Plan may be adopted by a subsidiary or affiliate of Meridian Health that the Plan Administrator authorizes to adopt the Plan and that, by appropriate corporate action, adopts the Plan. In such event, the Plan Administrator may determine the effective date of the Plan as to any such subsidiary or affiliate and each such subsidiary or affiliate shall thereupon be included within the term "Company" to the extent provided in Section 2.09. The Plan Administrator may also determine the terms and conditions upon which any such subsidiary or affiliate may adopt the Plan.

The Plan Administrator (or the representative of the Plan Administrator) shall update Exhibit A as necessary to reflect the addition of any such affiliate or subsidiary.

13.02 Withdrawal of Subsidiary or Affiliate from Plan

Any subsidiary or affiliate of Meridian Health that has adopted the Plan in accordance with Section 13.01 may withdraw from the Plan by giving written notice of its intention to withdraw to the Plan Administrator, and any individual or entity which has ceased to be a subsidiary or affiliate of Meridian Health or has failed to meet its current costs of the Plan shall withdraw upon the request of Meridian Health. Each such subsidiary or affiliate shall thereupon cease to be included within the term "Company."

The Plan Administrator (or the representative of the Plan Administrator) shall update Exhibit A as necessary to reflect the withdrawal of any such subsidiary or affiliate.

ARTICLE XIV. HIPAA PRIVACY

14.01 Purpose and Applicability

This Article reflects certain provisions of HIPAA and the regulations thereunder. The provisions set forth herein apply to the Plan only to the extent that the Plan or any of the Covered Benefits constitutes a "health plan" under 45 CFR 160.103 that uses or discloses "protected health information" ("PHI") or "electronic protected health information" ("electronic PHI") as those terms are defined in the Standards for Privacy of Individually Identifiable Health Information, 45 CFR §§ 160 and 164, as amended from time to time, including without limitation as amended by the Health Information Technology for Economic and Clinical Health Act, part of the America Recovery and Reinvestment Act of 2009, (the "HIPAA Privacy Rules") and 45 CFR §§ 160, 162 and 164, as amended from time to time (the "HIPAA Security Rule"). For purposes of this Article XIV, terms defined in the HIPAA Privacy Rules and the HIPAA Security Rule, but not in this Plan, shall be interpreted and administered in accordance with those provisions and the term "Plan" shall be interpreted to include this Plan and the Covered Benefits to which this Article XIV applies.

14.02 Uses and Disclosures of PHI

a. Uses and Disclosures Generally

(i) Permitted and Required Uses and Disclosures. The Privacy Officer shall use and disclose PHI in accordance with the HIPAA Privacy Rules, including to the extent that he determines that:

(A) such use or disclosure is needed for the "payment" of Plan claims, the "treatment" of Covered Employees and/or Covered Dependents under the Plan, or the "health care operations" of the Plan, as such terms are defined in the HIPAA Privacy Rules, provided however, that the Plan shall not use or disclose PHI that is genetic information for underwriting purposes;

(B) such use or disclosure is required or permitted by law;

(C) such use or disclosure has been authorized by the relevant individual(s) in accordance with the HIPAA Privacy Rules;

(D) such use or disclosure is appropriate under Section 14.03, Section 14.04, or Section 14.05; or

(E) such use or disclosure is made to a person involved, as determined by the Privacy Officer or Claims Administrator, in the relevant individual's care.

(ii) Certification by Plan Sponsor. Unless specifically permitted by law, the Privacy Officer shall not disclose any PHI to the Plan Sponsor unless: (A) such disclosure is to enable the Plan Sponsor to perform "plan administration functions" as

described in the HIPAA Privacy Rules and (B) the Plan Sponsor has certified that this Plan document has been amended to incorporate the requirements of 45 CFR 164.504(f)(2)(ii) of the HIPAA Privacy Rules and has agreed to comply with these requirements.

(iii) No Other Uses or Disclosures. In no event shall the Privacy Officer or the Plan Sponsor use or disclose PHI for employment-related actions or decisions, in connection with any other benefit plan, or for any other purpose other than as required by law or as required or permitted by this Plan document. The Plan shall not disclose PHI to the Plan Sponsor, or any subsidiary or affiliate participating under the Plan, other than for purposes of performing "plan administrative functions" as defined in the HIPAA Privacy Rules.

(iv) Business Associates. To the extent required by law, the Privacy Officer shall not disclose PHI to a Claims Administrator or any other individual or entity that constitutes a "business associate" under the HIPAA Privacy Rules, except as provided under a "business associate agreement" that meets the requirements of the HIPAA Privacy Rules.

(v) Minimum Necessary. The Plan shall follow any guidance issued by the Department of Health and Human Services ("HHS") regarding what constitutes "minimum necessary" with respect to the use or disclosure of PHI. Until the time that such guidance is issued, the Plan shall limit its uses or disclosures of PHI, to the extent practicable, to the "limited data set" (as defined in 45 CFR 164.514(e)(2)), or the minimum information necessary to accomplish the intended purpose of such use or request.

(vi) Summary Health Information. Notwithstanding the foregoing, the Plan or Plan's workforce may disclose summary health information to the Company, if the Company requests the summary health information for purposes of (A) obtaining premium bids from health plans for providing health insurance coverage or (B) modifying, amending, or terminating the Plan. The Plan, Plan's workforce, or applicable insurer may disclose to the Company information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(vii) Authorization Required for Certain Uses or Disclosures. Except as permitted by HIPAA or the regulations and guidance issued thereunder, the Plan shall not engage in the marketing or sale of PHI unless the Plan first obtains a valid authorization from the individual to the extent required by and in accordance with the requirements for valid authorizations set forth in the HIPAA Privacy Rules.

b. Administrative Requirements

(i) Separation of Plan Administration and Plan Sponsor. Access to PHI for Plan administration purposes shall be limited to:

(A) the Privacy Officer and contact person; and

(B) those individuals who, at the time of the relevant use or disclosure of PHI, are assigned to perform specific Plan administrative functions that involve the use or disclosure of PHI.

None of the individuals identified in the preceding sentence shall have access to PHI, except as reasonably necessary to perform the Plan administrative functions which are assigned or delegated to them. In case of any delegation, the individual to whom duties are assigned shall be required to comply with the provisions of this Article XIV. Beyond the individuals identified in this Section, no other individuals employed by the Plan Sponsor shall have access to PHI.

(ii) Privacy Officer and Contact Person. The "Privacy Officer" of the Plan, who shall be appointed by the Plan Administrator or its designee in accordance with Article XIV, shall be responsible for the development and implementation of the Plan's privacy policy (as provided in the HIPAA Privacy Rules) and administrative procedures. The contact person for the Plan, who shall be appointed by the Plan Administrator or the Privacy Officer, shall be responsible for receiving Covered Employee and Covered Dependent complaints and responding to requests for additional information about such policies and procedures. The Privacy Officer may delegate its duties as described in this Section 14.02 to the contact person, an individual designated as having access to PHI in accordance with Section 14.02(b)(i), or a business associate (including a Claims Administrator), to the extent necessary and appropriate for the proper and efficient administration of the Plan and compliance with the HIPAA Privacy Rules.

(iii) Noncompliance. Any individual identified in Section 14.02(b)(i) who fails to comply with the Plan's privacy policy and related procedures shall be subject to the same disciplinary rules and procedures that apply to breaches of the employment policies of the Plan Sponsor, unless and until the Plan Administrator establishes specific rules for violation of the terms of this Article XIV.

c. Legal Standards

(i) Right to Revise Policies and Notice. To the fullest extent allowed by the HIPAA Privacy and Security Rules, the Privacy Officer shall be permitted to modify the privacy policy and/or the security policy and notify Covered Employees and Covered Dependents of those modifications.

(ii) More Stringent State Law. This Plan shall be administered and interpreted to comply with any applicable state law regarding health information privacy and security, except to the extent that such state law is preempted by ERISA or HIPAA or another federal law.

(iii) Cooperate with HHS. The Privacy Officer shall disclose PHI, and its internal practices, books, and records, as required, to HHS for the purpose of investigating or determining compliance with the HIPAA Privacy and Security Rules and the statutory provisions that they interpret.

14.03 Access and Copying of PHI

a. Access

A Covered Employee's or Covered Dependent's access to his or her PHI shall be governed by this Section 14.03 and 45 CFR 164.524. This Section applies to PHI that is maintained by the Privacy Officer or a Claims Administrator, except: psychotherapy notes; information compiled with a reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding; and information that is not part of a "designated record set" as defined in the HIPAA Privacy Rules.

b. Administration of Written Requests

An individual may request access to, inspect, and copy his or her PHI using forms and procedures established by the Privacy Officer or Claims Administrator, as applicable. Such request may also be made by a personal representative (as described in the HIPAA Privacy Rules) of the individual, in which case the provisions of this Section 14.03 will apply to the personal representative as if he or she were the individual to whom the PHI relates.

The Privacy Officer or Claims Administrator will grant or deny the request in writing within 30 days of its receipt of the request, unless it is unable to do so and during that 30-day period provides the individual with a written statement of the reasons for the delay and the date on which the Privacy Officer or Claims Administrator will grant or deny the request. In no event will this extension period exceed 30 days.

c. Request Granted

If the Privacy Officer or Claims Administrator grants an individual's request to either inspect PHI or copy it, or both, the Privacy Officer or Claims Administrator will give the individual such access to the PHI requested. If the PHI is requested in a format in which the PHI can be readily produced, then the PHI will be produced in that requested format. If the PHI cannot be readily produced in the requested format (as determined by the Privacy Officer or Claims Administrator), the Privacy Officer or Claims Administrator may provide it in readable hard copy format or some other form agreed to by the individual. Alternatively, if the PHI that is requested is maintained in a designated record set electronically and the individual requests an electronic copy, the Privacy Officer or Claims Administrator must provide access to the PHI in the electronic form and format requested, if it is readily producible in such form and format, or, if not, in a readable electronic form and format as agreed to by the Privacy Officer or Claims Administrator and the individual. The Privacy Officer or Claims Administrator will arrange for access to the requested PHI to take place within the time periods described in Section 14.03(b). The Privacy Officer will arrange a time and place for the individual to access, inspect, and/or copy the PHI or will mail a copy of the PHI at the individual 's request. If the individual requests in a signed writing that the requested PHI be provided directly to another person clearly identified I the request, then the Privacy Officer or Claims Administrator will transmit the PHI to such designated individual. The Privacy Officer or Claims Administrator may impose a reasonable, cost-based fee for providing requested PHI if the fee includes only the cost for labor for

copying (whether in paper or electronic form) and supplies for creating the paper copy or electronic media (if requested in electronic media).

d. Request Denied

(i) The Privacy Officer or Claims Administrator may deny an individual ’s request and such denial will be considered final in the following cases:

(A) the PHI is excepted from the right of access as specified in subparagraph (a) above;

(B) the PHI is created or obtained in the course of ongoing research as described in the HIPAA Privacy Rules and the individual consented to the restricted access when he or she agreed to participate in the research;

(C) the PHI is contained in records subject to the Federal Privacy Act and may be denied under that Act; or

(D) the PHI was obtained from someone other than a health care provider under a promise of confidentiality and access would be reasonably likely to reveal the source of the information.

(ii) The Privacy Officer or Claims Administrator may deny an individual ’s request for access to PHI, provided that the individual is allowed to have such denial reviewed, if a licensed health care professional, in the exercise of professional judgment, has determined that the access requested is:

(A) reasonably likely to endanger the life or physical safety of the individual or another person;

(B) reasonably likely, if the PHI refers to another person, to cause substantial harm to that person; or

(C) reasonably likely, if the access is requested by an individual’s personal representative, to cause substantial harm to the individual or another person.

(iii) If the Privacy Officer or Claims Administrator partially denies an individual’s request for access to certain PHI under Section 14.03(d)(ii), the Privacy Officer or Claims Administrator will make other PHI requested available to the individual . Additionally, if a request of PHI is denied (in whole or in part), the Privacy Officer or Claims Administrator will provide the individual with a timely denial written in plain language and containing the basis for the denial; a statement of the individual ’s review of denial rights (if applicable) and how to exercise those rights; and a description of how the individual may submit a complaint. If the Privacy Officer or Claims Administrator does not maintain the PHI requested, but knows where it is maintained, the Privacy Officer or Claims Administrator must inform the individual where the request should be directed.

(iv) If an individual's request for access is denied under Section 14.03(d)(ii), the individual may request to have the denial reviewed by a licensed health care professional whom the Privacy Officer or Claims Administrator has designated as the reviewing official and who did not participate in the original decision to deny the request. The Privacy Officer or Claims Administrator will promptly refer the request for review to the designated reviewing official, who will then determine whether or not to deny the access requested based on the acceptable grounds for denial described in Section 14.03(d)(ii). The Privacy Officer or Claims Administrator will promptly provide written notice to the individual of that determination and take action necessary to carry out this determination.

14.04 Amending PHI

a. Ability to Amend

An individual's ability to amend his or her PHI shall be governed by this Section 14.04 and 45 CFR 164.526. This Section applies to an individual's PHI that is maintained by the Claims Administrator or Privacy Officer, except: psychotherapy notes; information compiled with a reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding; or information that is not part of a "designated record set" as defined in the HIPAA Privacy Rules.

b. Requests for Amendment and Plan Response

An individual may request an amendment in writing, using forms and procedures established by the Privacy Officer or Claims Administrator, as applicable, if such request is supported by a reason to amend. Such request may also be made by a personal representative of the individual, in which case the provisions of this Section 14.04 will apply to the personal representative as if he or she were the individual. The Privacy Officer or Claims Administrator will act on the written request no later than 60 days after receipt of such request. If the Privacy Officer or Claims Administrator is unable to act within this time, it may extend the period for up to 30 days by providing the individual with a written statement of the reason for the delay and the date by which the Privacy Officer or Claims Administrator will complete its action on the request.

c. Amendment Granted

If the Privacy Officer or Claims Administrator grants the requested amendment (in whole or in part), it must make the appropriate amendment to the PHI or pertinent record. Such amendment will identify the affected PHI or records and append or otherwise provide a link to the location of the amendment. The Privacy Officer or Claims Administrator must also timely inform the individual that the amendment is accepted and obtain the individual's agreement to inform: (i) those identified by the individual as having received the PHI and needing the amendment, and (ii) those known by the Privacy Officer or Claims Administrator to have received the PHI and that may foreseeably rely on the PHI to the detriment of the individual .

d. Amendment Denied

(i) Reasons for Denial. The Privacy Officer or Claims Administrator may deny a request for amendment if the PHI:

(A) was not created by, or on behalf of, the Plan (unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment);

(B) is not part of a "designated record set" as defined in the HIPAA Privacy Rules;

(C) would not be available for individual access under Section 14.03; or

(D) is accurate and complete without the amendment.

(ii) Notice of Denial. If the Privacy Officer or Claims Administrator denies the request for amendment, it will send the individual a denial written in plain language that contains a statement describing:

(A) the basis for the denial;

(B) the individual's right to submit a written statement disagreeing with the denial and how such statement may be filed;

(C) how, if a statement of disagreement is not filed, the individual may request that the Privacy Officer or Claims Administrator include the request for amendment and the denial with any future disclosures of the PHI which is the subject of the requested amendment; and

(D) the complaint procedures, including name or title and telephone number of the designated contact person or office.

(iii) Statement of Disagreement. If an individual request for amendment is denied, the individual may file a written statement of disagreement. Such statement must be of a reasonable length and must be filed using forms and procedures established by the Privacy Officer or Claims Administrator.

(iv) Rebuttal Statement. Whenever an individual submits a statement of disagreement under Section 14.04(d)(iii), the Privacy Officer or Claims Administrator may prepare a written rebuttal to that statement. The Privacy Officer or Claims Administrator will provide a copy of that rebuttal to the affected individual .

(v) Future Disclosures. The Privacy Officer or Claims Administrator will identify the PHI and append or otherwise link the amendment, denial, statement of disagreement, and rebuttal to the relevant records. The Privacy Officer or Claims Administrator will include such information, or an accurate summary of such information, with all future disclosures of the PHI if the individual submitted a statement of disagreement. If the disclosure is made using a standard transaction that does not

permit the material to be included with the disclosure, the Privacy Officer or Claims Administrator may transmit the material separately. If the individual does not submit a statement of disagreement, the Privacy Officer or Claims Administrator will include the request for amendment and denial with future disclosures only if the individual makes such a request. If the Privacy Officer or Claims Administrator receives notice from another "covered entity" (as defined in the HIPAA Privacy Rules) about an amendment to an individual's PHI, the Privacy Officer or Claims Administrator must amend the PHI accordingly.

14.05 Accounting for Disclosures of PHI

a. Accounting of Disclosures

An individual's ability to receive an accounting of disclosures of his or her PHI is governed by this Section 14.05 and 45 CFR 164.528. An individual may request an accounting of disclosures of PHI made by the Privacy Officer or Claims Administrator for any period less than six years prior to the date of the request unless the disclosure was: (i) to carry out treatment, payment and health care operations as provided in Section 14.02(a)(i)(A); (ii) to the individual ; (iii) to persons involved in the individual's care or other notification purposes provided for in the HIPAA Privacy Rules; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement officials; or (vi) made pursuant to a valid authorization. A request for an accounting of disclosures of an individual's PHI may also be made by a personal representative of the individual, in which case the provisions of this Section 14.05 will apply to the personal representative as if he or she were the individual.

b. Accounting for Disclosures of PHI Made Through Use of an Electronic Health Record

If disclosures are made through the use of an electronic health record, an individual may also request an accounting of disclosures made for treatment, payment and health care operations for any period less than three years prior to the date of the request as follows:

(i) If the Plan implements an electronic health record after January 1, 2009, then an individual may request an accounting of such disclosures beginning on the later of January 1, 2011, or the date on which the Plan implements the electronic health record; or

(ii) If the Plan implemented an electronic health record prior to January 1, 2009, then an individual may request an accounting of such disclosures beginning on or after January 1, 2014.

c. Temporary Suspension

The Privacy Officer or Claims Administrator may temporarily suspend an individual's ability to receive an accounting of disclosures made to a health oversight agency or law enforcement official if the accounting would be reasonably likely to

impede the agency's or official's activities. The ability may only be suspended if the relevant agency or official provides the Privacy Officer or Claims Administrator with a written or oral statement specifying such impediment and the time for which the suspension is required. If this statement is an oral statement, the Privacy Officer or Claims Administrator will document the oral statement, including the identity of the agency or official making the statement; temporarily suspend the right to an accounting subject to the statement; and limit the suspension to no more than 30 days from the date of the oral statement unless a written statement is submitted during that time period.

d. Content of the Accounting

For each disclosure made, the written accounting will include: the date of disclosure; the name and address of the recipient of the PHI; a brief description of the PHI disclosed; and the purpose of the disclosure. (In lieu of a description of the purpose of the disclosure, the Privacy Officer may provide a copy of the individual 's written authorization under the HIPAA Privacy Rules, or a copy of the written request for a disclosure pursuant to an HHS investigation or as permitted by the HIPAA Privacy Rules.) If the Privacy Officer or Claims Administrator makes multiple disclosures of PHI to the same person or entity for a single purpose, the accounting prepared by the Privacy Officer or Claims Administrator need only include complete information for the first disclosure, and the frequency or number, including the date of the last such disclosure, for subsequent disclosures.

e. Administrative Requirements

The Privacy Officer or Claims Administrator must act on the individual's request for an accounting no later than 60 days after the receipt of such request. The Privacy Officer or Claims Administrator may extend this period for up to 30 additional days if it provides the individual with a written statement of the reason for the delay and the date by which the accounting will be provided. The first accounting requested in any twelve-month period will be provided free of charge, but each subsequent request made within that same period will be charged a cost-based fee for completing the requested accounting. The Privacy Officer or Claims Administrator will inform the individual of such fee in advance and provide the individual the opportunity to withdraw or modify the request for a subsequent accounting.

14.06 Requests for Restrictions and Confidential Communications

a. Restrictions

Restrictions on individual PHI shall be governed by this Section 14.06(a) and 45 CFR 164.522(a). Under this Section, an individual may request that the Privacy Officer or Claims Administrator restrict uses or disclosures of PHI about the individual to carry out treatment, payment or health care operations.

(i) Granting a Restriction. Subject to any exceptions contained in HIPAA or the regulations issued thereunder, the Privacy Officer or Claims Administrator is not required to agree to restriction; provided, however, the Privacy Officer or Claims

Administrator must agree to restrict disclosure of PHI about the individual to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan, has paid in full. If the Privacy Officer or Claims Administrator agrees to a restriction, the Plan may not use or disclose the applicable PHI in violation of the restriction.

(ii) Disclosures to Family Members and Other Designated Individuals. The Privacy Officer or Claims Administrator will agree to a request by an individual to refrain from disclosing such individual's PHI to his or her family members or other individuals involved in the individual's health care or payment for such care. If an individual does not request such a restriction, the Privacy Officer or Claims Administrator may, in its administration of the Plan, disclose PHI to the applicable individual's family members at such member's request.

(iii) Use or Disclosure of Restricted PHI. Even if the Privacy Officer or Claims Administrator agrees to the restriction, the PHI subject to the restriction may be disclosed if it is needed to provide emergency treatment, provided that the Privacy Officer or Claims Administrator requests that the recipient of the restricted PHI refrains from further disclosing the PHI. Also, a restriction shall not be effective for uses and disclosures requested by HHS or uses and disclosures for which the individual would not otherwise have the opportunity to agree or object.

(iv) Terminating a Restriction. The Privacy Officer or Claims Administrator may terminate a restriction, if:

(A) the relevant individual agrees to the termination in writing;

(B) the relevant individual orally agrees to the termination of the restriction if the Privacy Officer or Claims Administrator documents the oral agreement; or

(C) the Privacy Officer or Claims Administrator informs the relevant individual that it is terminating its agreement to restrict PHI (provided that such restriction is not required by HIPAA or any regulations issued thereunder), except that such termination shall be effective only with respect to PHI created or received after it has so informed the individual and will not apply to PHI that must be restricted under Section 14.06(a)(i).

b. Confidential Communications

Individual requests for confidential communications shall be governed by this Section 14.06(b) and 45 CFR 164.522(b). An individual may request, in writing, to receive communications of PHI from the Privacy Officer or Claims Administrator by alternative means or at alternative locations. The Privacy Officer or Claims Administrator shall accommodate reasonable requests for confidential communications if such requests clearly state that the disclosure of all or part of that information could endanger the individual.

14.07 Additional Obligations of Plan Sponsor

a. Compliance by Business Associates

Any business associates to whom the Plan Sponsor provides PHI received from the Plan must agree to the same restrictions and conditions that apply to the Plan Sponsor. Any contract between the Plan or Plan Sponsor and any business associate providing services to the Plan must comply with the requirements of the HIPAA Privacy Rules.

b. Report Improper Uses or Disclosures

If the Plan Sponsor becomes aware of any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this Plan document or under the HIPAA Privacy Rules, the Plan Sponsor will report such use or disclosure to the Privacy Officer or its designee.

c. Notify in the Event of a Breach of Unsecured PHI

The Plan will comply with the requirements of HIPAA and its implementing regulations to provide notification to affected individuals, HHS and the media (when required) if the Plan or one of its business associates discovers a Breach of Unsecured PHI (as defined in 45 CFR 164.402).

d. Destroy PHI or Retain Protections

The Plan Sponsor must return or destroy all PHI received from the Privacy Officer that the Plan Sponsor still maintains in any form at the time when it is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make return or destruction infeasible.

e. Cooperate With HHS

The Plan Sponsor shall disclose PHI, its internal practices, books, and records, as required, to HHS for purposes of investigating or determining compliance with the HIPAA Privacy Rules and their underlying statutory provisions.

14.08 Health Information Security

a. General

The rules in this Section 14.08 govern the security of PHI under the Plan. This Section 14.08 is intended to demonstrate good faith compliance with the health information security requirements of the HIPAA Security Rule and is to be construed in accordance with HIPAA and the guidance and regulations issued thereunder. For purposes of this Section 14.08, terms defined in the HIPAA Security Rule but not in this Plan shall be interpreted and administered in accordance with the HIPAA Security Rule.

b. Security Officer

The security officer of the Plan shall be appointed by the Plan Administrator and shall be responsible for the development and implementation of the Plan's security policies (as required by the HIPAA Security Rule) and administrative, technical and physical safeguards to protect the integrity and security of electronic PHI. If the Plan Administrator fails to appoint a security officer, the Plan Administrator shall serve as security officer of the Plan.

c. HIPAA Security Rule Compliance

In accordance with HIPAA, the Plan Sponsor shall:

(i) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Plan;

(ii) ensure that adequate separation, as required by the HIPAA Security Rule, is supported by reasonable and appropriate security measures;

(iii) require any entity, including a subcontractor, to whom it provides this information to agree to implement reasonable and appropriate security measures to protect the electronic PHI;

(iv) report to the Plan any successful unauthorized access, use, disclosure, modification or destruction of electronic PHI or interference with system operations in an information system containing PHI of which the Plan Sponsor becomes aware; and

(v) report to the Plan the aggregate number of unsuccessful attempts to access, use, disclose, modify or destroy electronic PHI, or interfere with systems operations in an information system containing PHI, of which the Plan Sponsor becomes aware.

ARTICLE XV. MISCELLANEOUS

15.01 No Employment Rights

The Plan is a voluntary undertaking of the Company and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with the Company. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed (i) as giving to any Employee or any other person, any legal or equitable rights against the Company or its shareholders, trustees, officers, employees or agent; (ii) as giving any person the right to be retained in the employ of the Company, or (iii) to interfere with the right of the Company to discharge any Employee at any time, regardless of the effect such discharge might have upon such person as a Covered Employee in the Plan.

15.02 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

15.03 No Property Rights

No one has any right, title, or interest in the property of the Company by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

15.04 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to a the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of New Jersey.

15.05 Governing Instrument

This document, together with the documentation incorporated by reference into it, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

15.06 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

15.07 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan have been inserted solely for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

15.08 Notices

No notice or communication in connection with the Plan made by a claimant, an Employee, or a Covered Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or the representative of the Plan Administrator) unless made in compliance with an alternate procedure expressly specified in the applicable SPD.

15.09 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing wavier unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

15.10 Indemnification

The Company, to the maximum extent permitted by law, its corporate charter, and its bylaws, shall indemnify and hold harmless, directly from its own assets (including the proceeds of any liability insurance policy the premiums of which are paid from the Company's own assets), the Board of Trustees and any employee, officer, or shareholder of the Company from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

15.11 Gender and Number

Unless the context clearly indicates otherwise, words in any gender shall include any other gender, the plural shall include the singular, and the singular shall include the plural.

IN WITNESS WHEREOF, The Company has caused this duly adopted Plan to be executed below by its duly authorized representative on this _24th____ day of _January_____, 2015.

MERIDIAN HEALTH

By:_Sherrie String, SVP Human Resources_____
(original signature on file)

EXHIBIT A

PARTICIPATING SUBSIDIARIES AND AFFILIATES

The following affiliated or subsidiary companies have been designated as participating employers in the Plan with respect to their Employees by the Board of Trustees. The effective dates of their participation are listed below.

Participating Employer and EIN	**Effective Date (if after January 1, 2013)**	**Termination Date**
Meridian Hospitals Corporation 22-3471515		
Meridian Nursing & Rehabilitation, Inc. 52-1772578		
Bayshore Health Care Center, Inc. 22-1772578		
The Willows at Holmdel 52-1772578		
Meridian Health Foundation, Inc. 30-0107825		
Meridian Home Care Services, Inc. 22-2731440		
Health Innovations Unlimited 22-2581430		
Meridian Pediatric Associates, P.C. 06-1755230		
Meridian Obstetrics & Gynecology Associates, P.C. 06-1755239		
Meridian Medical Associates, P.C. 06-1755233		
Meridian Pediatric Surgical Associates, P.C. 77-0720131		
Meridian Surgical Associates, P.C. 06-1755228		
Meridian Trauma Associates, P.C. 14-1981651		
Northern Monmouth County Medical Associates, P.C. 14-1981647		
Northern Ocean County Medical Associates, P.C. 14-1981653		
SOMC Medical Group, P.C. 27-1412183		

Meridian Health Realty 22-3200147		
Meridian Health Resources 22-2620595		
Shore Rehabilitation Institute, Inc. 22-3274755		
Health Village Imaging, L.L.C. 20-3411350		
Allergy & Pediatrics Associates of New Jersey Shore, P.C. 22-3468694		
Ear, Nose, Throat & Facial Plastic Surgery Associates, P.C. 22-3522954		
Jersey Shore Associates in Internal Medicine of Marlboro, P.C. 22-3566714		
Jersey Shore Bethany Pediatrics, P.C. 22-3554900		
Jersey Shore Internal Medicine & Family Practice Associates, P.C. 22-1892659		
Jersey Shore Medical Associates, P.C. 22-3318056		
Jersey Shore Monmouth County Associates 22-3607249		
Jersey Shore Monmouth Family Medicine Group, P.C. 22-3802205		
Jersey Shore Navesink Pediatrics, P.C. 22-3554905		
Jersey Shore Tinton Falls Medical Associates, P.C. 22-3668383		
WLB Medical Associates, P.C. 54-2074684		
Qualify Care Management 22-3557994		

EXHIBIT B

COVERED BENEFITS

Each Covered Benefit is described in its separate insurance certificate or SPD, which documents are incorporated by reference into the Plan. The following Covered Benefits comprise the Plan.

Covered Benefit	**Insurer or Third Party Administrator**
Meridian Health Team Member Medical Benefit Plan	
QualCare Inner Circle Option	QualCare, Inc. (TPA)
QualCare PPO Option	QualCare, Inc. (TPA)
QualCare Consumer Driven Health Plan	QualCare, Inc. (TPA)
Prescription Drug	EnvisionRxOptions (TPA)
Meridian Health Dental Plan	
HealthPlex Option	IHS/Healthplex
Horizon Gold (Dental Option Plan)	Horizon BlueCross Blue Shield of New Jersey
Horizon Silver (Dental Preventive PPO Access Plan)	Horizon BlueCross Blue Shield of New Jersey
Horizon Bronze (Dental Choice Plan)	Horizon BlueCross Blue Shield of New Jersey
UnitedHealthcare Vision Plan	UnitedHealthcare Insurance Company
Meridian Health Life Insurance Plan	NJHA Insurance Fund
Meridian Health Group Long-Term Disability Insurance Plan	Reliance Standard Life Insurance Company
Meridian Health Flexible Benefits Program • Pre-Tax Premium Option • Health Flexible Spending Account • Dependent Care Flexible Spending Account • Health Savings Account	WageWorks, Inc. Wells Fargo Bank, N.A.
AccidentAdvance Accident Insurance	Transamerica Life Insurance Company
CancerSelect Plus Cancer Only Indemnity Insurance	Transamerica Life Insurance Company
CriticalAssistance Plus Critical Illness Insurance	Transamerica Life Insurance Company

Short-Term Disability Insurance	Unum
Whole Life Insurance (with Long-Term Care Rider)	Unum