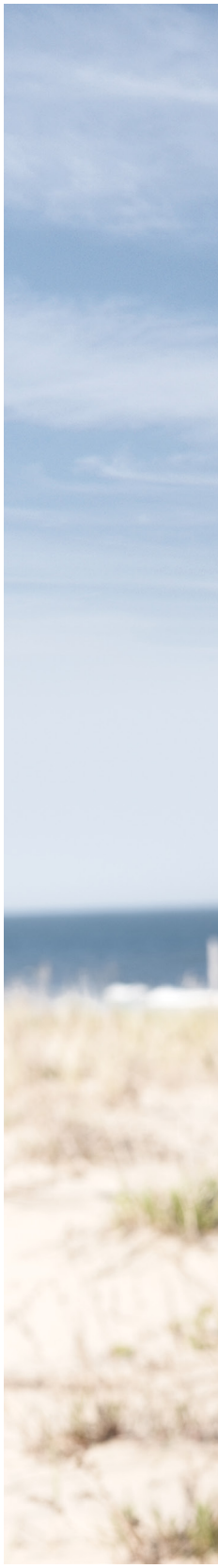
EMPLOYEE ASSISTANCE PROGRAM



MERIDIAN HEALTH

Meridian Health Employee Assistance Program

A Partnership "TOTAL REWARDS" Program

SUMMARY OF THE MERIDIAN HEALTH EMPLOYEE ASSISTANCE PROGRAM

INTRODUCTION

This Summary provides the terms and conditions for eligibility and benefits under the Meridian Health Employee Assistance Program (the "Plan"). With respect to the portions of the Plan that are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), this Summary constitutes the "summary plan description" required under ERISA. It is intended to be a comprehensive description of the participation requirements and available benefits under the Plan. Please keep it for your reference. The Plan is sponsored by Meridian Health for the benefit of eligible team members of the Employer and its affiliates, and is a component plan of the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan").

While Meridian Health expects to continue the benefits described in this Summary, it reserves the right to terminate, suspend, discontinue or amend one or more of the benefits or other terms and conditions (including eligibility rules, cost sharing, benefit exclusions, and others) at any time and for any reason, as described in Amending and Terminating the Plan.

PARTICIPATION AND ENROLLMENT

Eligibility

As an active team member of Meridian Health or a Participating Employer (an "Employer"), you and your eligible dependents can utilize the Plan.

Eligible Team Members.

For purposes of the Plan, a team member is any individual who is treated by an Employer as its common law employee, who is on the regular payroll of the Employer, and whose compensation is reported by the Employer on IRS Form W-2.

Team members who are represented by a labor union may, or may not, be eligible for any or all of the benefits described in this SPD. The eligibility of represented team members for these benefits may be governed by the applicable collective bargaining agreement(s) and/or be subject to collective bargaining.

Eligible Classes of Dependents.

A "Dependent" is any one of the following persons:

(1) Legal Spouse. The term "Spouse" shall mean the person lawfully married to a team member under the laws of any domestic or foreign jurisdiction where such individual and eligible employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

(2) Civil Union Partner. The term "Civil Union Partner" means a person who has established and is in a Civil Union with a team member. A "Civil Union" is a same-sex civil union that is either established pursuant to New Jersey law or recognized by the State of New

Jersey as a civil union. The Plan Administrator may require documentation proving a legal Civil Union.

(3) Domestic Partner. A Domestic Partner (as defined below) who (a) entered into a Domestic Partnership with a team member prior to January 1, 2014 and (b) has provided the applicable proof requirements, is eligible for coverage under the Plan. It is required that you provide an affidavit of domestic partnership and documents evidencing joint responsibility. The following documentation for coverage for a domestic partner is acceptable: joint mortgage or lease; designation of the domestic partner as a primary beneficiary for a life insurance or a retirement contract; designation of the domestic partner as a primary beneficiary in the team member's will; durable power of attorney for healthcare or financial management; joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party.

"Domestic Partners" are an eligible team member and one other person who:

- have been living in a committed exclusive relationship of mutual caring and support for a period of at least twelve (12) months;
- intend for the domestic partnership to be permanent;
- are financially interdependent and jointly responsible for the common welfare and financial obligations of the household;
- is not legally or ceremonially married to any other individual, and, if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased;
- are mentally competent to enter into a contract according to the laws of the state in which they reside;
- are 18 years of age or older;
- are the same gender;
- do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside, if all other applicable marriage requirements of such state law were met;
- are not in the relationship solely for purposes of obtaining benefits; and
- if you live in a municipality or state that registers same sex domestic partners, you must be registered and provide the Plan Administrator with a copy of the registration.

(4) Child(ren). Child(ren) who have not attained age 26 will be eligible for coverage under the Plan. The term "children" or "child" shall include your natural children, adopted children, step-children, foster children, children placed with you in anticipation of adoption or becoming your foster child, unmarried child for whom you are the court-appointed legal guardian, or your Domestic Partner's or Civil Union Partner's children. The phrase "child placed with you in anticipation of adoption" refers to a child who is lawfully placed with you for legal adoption by you.

Any child of a team member who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical child support order procedures are available upon request, at no charge.

(5) Disabled Child. A covered Dependent child who reaches the limiting age and is unmarried, totally disabled (i.e., he or she cannot engage in the normal activities of a person in good health and of like age and sex), incapable of self-sustaining employment by reason of mental or physical handicap, and primarily dependent upon the covered team member for support and maintenance; provided that the child became so incapacitated prior to reaching the limiting age and was enrolled in the Plan at that time. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Eligibility Requirements for Dependent Coverage. A family member of a team member will become eligible for Dependent coverage on the first day that the team member is eligible for coverage and the family member satisfies the requirements for Dependent coverage. Plan coverage is automatic. The team member does not need to enroll an eligible Dependent in order for the Dependent to be covered.

At any time, the Plan may require proof that a Spouse, Domestic Partner, Civil Union Partner, or child qualifies or continues to qualify as a Dependent as defined by this Plan.

Cost of the Plan

Meridian Health pays the full cost of the Plan. You do not need make any contributions

Termination of Coverage

Except as otherwise described in the Section entitled Continuation Coverage Rights, your and your Dependents' access to Plan services ends on the earliest of the following dates:

- The last day of the month in which you retire or otherwise end your employment;

- The last day of the month in which you become totally disabled, as defined by Meridian Health's long-term disability plan;
- The last day of the month in which you begin a leave of absence (If you are on an approved leave under the FMLA, your access to Plan services continues.)
- The day Meridian Health discontinues the Plan.

YOUR BENEFITS

How the Employee Assistance Program (EAP) Works

Meridian Health provides eligible team members and their Dependents with access to the Plan, which includes:

- Counseling services, which can help you handle any issues you are facing by providing sensitive, confidential support
- FinancialConnect
- LegalConnect

The Plan benefits are available through ComPsych, which is staffed by experienced professionals who provide personal and confidential counseling services. These experts can help you sort through issues and develop a solution you may not have considered on your own.

The services provided through the Plan are strictly confidential. ComPsych will not release any information about you or your family members unless you give written permission or unless the law requires it.

When You Need Help

You can reach ComPsych 24 hours a day, seven days a week. When you or a family member needs help, simply:

- Call ComPsych toll-free at 1-866-379-0244
- Visit GuidanceResources Online at www.guidanceresources.com and enter the Meridian Health company web ID, MERIDIAN

Counseling Services

The Plan's counseling services can provide you and your family members professional counseling and referral services, an opportunity to confidentially discuss personal and family problems for guidance and problem-solving help, and quality care by professional counselors and therapists.

The Plan can help you and your eligible Dependents by:

- Identifying the problem
- Recommending the appropriate counseling therapy and/or treatment
- Providing referrals to community service providers and treatment programs
- Giving confidential consultation

Contact with the Plan can be initiated in the following ways:

- Manager or supervisor referral
- Direct contact by team member

While Meridian Health cannot require you to participate in the Plan, your supervisor, manager, Meridian Connect, or Human Resources representative may recommend counseling. Your compliance may be a condition of continued employment in cases of serious performance or behavioral problems. However, participation in the Plan does not protect you from disciplinary action, up to and including termination of employment, if you continue to exhibit unacceptable performance or behavior. Essentially, you are responsible for the successful resolution of your problem through your willingness to seek help and treatment.

FinancialConnect®

The FinancialConnect program offers you unlimited telephone access to certified public accountants, certified financial planners, and other financial professionals who are trained and experienced in handling personal financial issues and can offer consulting on issues such as family budgeting, credit problems, tax questions, investment options, money management and retirement programs.

LegalConnect®

The LegalConnect program provides you with unlimited telephone consultation with attorneys who are trained and dedicated to providing legal information and assistance to clients with such issues as divorce, bankruptcy, family law, real estate purchases and wills.

If you need legal representation or extended assistance that cannot be provided by phone, LegalConnect professionals can provide referrals to local attorneys. You or your family member will receive a free 30-minute consultation and, thereafter, a 25% reduction in fees for representation if you choose one of ComPsych's network attorneys.

FamilySource®:

FamilySource provides team members and their family members with child and/or elder care resources in the team member's community. In addition, information on automobile purchases, relocation, pet services, travel and entertainment activity planning, personal services, apartment shopping, and mortgages.

Calling ComPsych

When you call ComPsych, a Guidance Resources counselor will listen to your concerns and obtain a referral for you to talk to an expert counselor located in your area. During the appointment, the counselor will discuss your situation and help you develop a plan of action. You can visit a ComPsych counselor up to five times at no cost to you. If it is determined that you need additional services beyond five visits, your medical plan may cover any additional care.

A ComPsych Guidance Resources counselor can help you deal with a variety of concerns, including:

- Depression
- Marital and family conflicts
- Drug and alcohol abuse
- Major life changes
- Relationship issues
- Anxiety and stress
- Eating disorders

Visiting GuidanceResources Online

GuidanceResources Online can help you obtain personal information for your life issues. At GuidanceResources Online, you can:

- Obtain information about personal, emotional, and life issues
- Read Helpsheets[SM] on your topic
- Review frequently asked questions
- Purchase expert-endorsed products and services to support your issue or lifestyle need
- Get book recommendations

Remember, you'll need to enter the Meridian Health company web ID to access the site: MERIDIAN.

If You Need Additional Help

In cases where your situation calls for care beyond ComPsych's counseling services, the medical coverage you have through Meridian Health can help. The benefits available depend on the medical option in which you have enrolled.

Relationship of Plan's Counseling Services to Other Medical Plans and Special Services

The Plan counseling services benefit is in addition to any medical coverage you have. Limited treatment services and programs may be covered under your medical option. Please refer

to the Meridian Health Medical Plan Summary Plan Description for an explanation of the coordination of benefits provisions and see the Meridian Health Medical Plan Summary Plan Description for any pre-certification, managed care, or notice requirements that apply to your medical option.

LEAVE OF ABSENCE

Your coverage under the Plan may be continued in the following circumstances:

Continuation During Periods of Employer-Certified Disability or Leave of Absence. Individuals who would otherwise lose coverage under the Plan as a result of losing team member status (for example, as a result of disability, leave of absence, layoff, etc.) may, to the extent permitted under the Employer's employment policies and procedures, temporarily continue Plan coverage in accordance with such policies and procedures; provided, however, that such coverage continuation is subject to other terms and conditions under the Plan and any subsequent changes to Plan terms and conditions.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the FMLA. During any leave that is a qualifying leave under the federal Family and Medical Leave Act (FMLA) (if applicable), Plan coverage will remain available to the extent required by FMLA.

CERTIFICATES OF CREDITABLE COVERAGE

Until December 31, 2014, and to the extent required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), each covered person will be provided a certificate of creditable coverage (i) when Plan coverage is lost (or would be lost in the absence of continuation coverage provided); and (ii) when continuation coverage ceases. In addition, a certificate of creditable coverage will be provided upon request to the Meridian HR Support Services Team by any covered person, or by any former covered person within 24 months after the date coverage ceases (including continuation coverage). A certificate of creditable coverage, which proves that the individual was covered under this Plan and indicates the period of coverage, may help reduce any pre-existing condition exclusion period under another health plan.

HOW TO SUBMIT A CLAIM

You do not have to file any claims when you use the Plan. The providers submit all claims for Plan services.

If the Claims Administrator determines that your situation is not covered under the Plan, you may dispute the determination by filing a written claim with the Claims Administrator. With regard to health benefits provided under the Plan, see the claims and appeals procedures in the Summary Plan Description for the Meridian Health Medical Plan for how to file a claim and how to appeal a denied claim. This Summary Plan Description can be found on the Meridian Health intranet or you may request a free copy by calling the HR Support Services Team. With regard to all other benefits provided under the Plan, see the claims and appeals procedures below.

Filing Claims

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

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

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

Claim Appeals

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

The Claims Administrator will notify you of the decision on appeal within 60 days after the Claims Administrator's receipt of the appeal, unless special circumstances require an

extension of up to 60 days for processing the claim. The notice will explain the special circumstances that require the extension and include the date by which the Claims Administrator expects to issue its determination on review.

If the decision on appeal is an adverse benefit determination, the Claims Administrator will provide you with a notification, which will include the following: (i) the specific reason or reasons for such adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; (iv) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA; and (v) any internal rule relied upon in making the adverse determination, or a statement that a copy of this information will be provided free of charge to you upon request.

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

CONTINUATION COVERAGE RIGHTS

Team Member Coverage

Your Plan coverage will continue for up to three years following your last day of employment.

Dependent Coverage

Generally, your Dependent's Plan coverage will end on the same date your coverage ends (three years following your last day of employment).

However, if one of the following events occurs prior to your termination of employment, your Dependent's Plan coverage will end on the date that is three years after the date of the event:

1. You die.

2. You become divorced or legally separated from your Spouse or you dissolve your Civil Union or Domestic Partnership.

3. Your Dependent ceases to satisfy the Plan definition of eligible Dependent.

The 3-year period during which Plan coverage continues following the events described above is provided by Meridian Health in lieu of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and continuation coverage under the Uniformed Services Employment and Reemployment Rights Act. The coverage being continued will be the same as the coverage provided to similarly situated individuals who have not experienced one of the events described above. If the benefits provided under the Plan to active team members are changed or eliminated, you may participate under the Plan, if any, made available to active team members.

If you have any questions or if you need more information about continuation of Plan coverage, please contact the Plan Administrator.

GENERAL PROVISIONS

Plan Administrator. The Board of Trustees of Meridian Health, or its delegate, is responsible for designating the person, committee, or entity that will serve as the Plan Administrator. Currently, the Plan Administrator is the Senior Vice President of Human Resources. The Plan Administrator is the named fiduciary of the Plan for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Administrator may allocate or delegate certain functions as it deems appropriate. The day-to-day operation of the Plan is managed by ComPsych, the Claims Administrator. The Claims Administrator has the discretionary authority to decide claims and appeals under the Plan.

Service of legal process may be made upon the Plan Administrator.

Duties and Authority of the Plan Administrator.

(1) To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.

(2) To make decisions and determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan, including deciding disputes which may arise relative to a Plan Participant's rights. Benefits under this Plan will be paid only if the Plan Administrator, or its designee or delegate decides in its discretion that the applicant is entitled to them.

(4) To describe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan Sponsor.

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

Plan Funding and Payment of Benefits. Plan benefits are paid from the general assets of the Employer. Benefits are generally paid through the Claims Administrator.

Plan is not an Employment Contract. The Plan is not to be construed as a contract for or of employment.

Clerical Error. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the Plan Administrator may deduct the amount of overpayment from future benefits payable.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continued health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

If you have a claim for the benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support money order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries

Employee Benefits Security Administration

U.S. Department of Labor

200 Constitution Avenue, N.W.

Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION	The benefits provided under the Plan are self-funded and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer. The Plan is not insured.
PLAN NAME	Meridian Health Employee Assistance Program
PLAN NUMBER	The Plan is part of the Welfare Benefit Plan of Meridian Health, and the plan number is 501
TAX ID NUMBER	223471515
PLAN YEAR	January 1 - December 31
TYPE OF PLAN	Health and welfare and fringe benefit plan
EMPLOYER PLAN SPONSOR INFORMATION	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
PARTICIPATING EMPLOYERS	See Appendix A
PLAN ADMINISTRATOR	Senior Vice President of Human Resources Meridian Health 1430 Rt. 34 Neptune, New Jersey 07753
NAMED FIDUCIARY	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
AGENT FOR SERVICE OF LEGAL PROCESS	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
TYPE OF ADMINISTRATION	Contract Administration
CLAIMS ADMINISTRATOR	ComPsych

APPENDIX A
LIST OF PARTICIPATING EMPLOYERS

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

ACTIVE/ 4988379.3