Monmouth University Cafeteria Plan

Summary Plan Description

Introduction

Monmouth University (the "Employer") sponsors the Monmouth University Cafeteria Plan (the "Plan") that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary describes the basic features of the Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Plan, and you should refer to the official Plan documents for more extensive information. You can contact the Plan Administrator for a copy. If there is a conflict between the Plan documents and this Summary, then the Plan documents (including any amendments) will control unless otherwise required by law.

Q-1. How do employees pay for benefits on a pre-tax basis?

An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer. Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-2. What benefits may be elected under the Plan?

The Plan includes the following benefits, each of which is referred to as a "Component Plan" and is described in more detail in the Component Plan document:

- *Premium Payment Component*—permits an Employee to pay for his or her share of contributions for the Insurance Plans listed in Schedule A, including medical, dental, and vision insurance, with pre-tax dollars.

  Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called Premium Payment Benefits.

  If you choose to waive medical coverage for you and/or your family, you may be eligible for a financial incentive. See the Employer's Voluntary Financial Incentive – Medical policy and your Benefits Guide for more information.

- *Health Flexible Spending Account (Health FSA) Component*—permits an Employee to pay for his or her qualifying Medical Care Expenses that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits.

- *Dependent Care Flexible Spending Account (Dependent Care FSA) Component*—also called a dependent care flexible spending account—permits an Employee to pay for his or her qualifying Dependent Care Expenses with pre-tax dollars. Benefits provided under the Dependent Care FSA are called Dependent Care FSA Benefits.

For purposes of the various insured Component Plans, the terms Spouse and Dependent are defined as provided in the Component Plans. For purposes of the other benefits, Spouse means a person to whom you are legally married under federal law. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. If permitted by a Component Plan, your civil union partner may be eligible for after-tax coverage. See the Plan Administrator for more information about which individuals will qualify as your Spouse or Dependents. You may be required to provide proof of your Dependents' eligibility at any time.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you during open enrollment.

Q-3. Who can participate in the Plan?

Employees who are eligible include Employees classified by the Employer, consistent with the Employer's personnel policies, as full-time faculty or non-faculty staff working at least 30 hours per week and, to the extent necessary, former Employees who are entitled to receive benefit payments under this Plan. In addition, if you are participating in the Plan and you were employed by the Employer before October 31, 2001 and are authorized to and regularly work at least 25 hours per week, you will continue to be eligible for the Plan. You are not eligible for the Plan if you are classified by the Employer as adjunct faculty, an on-call employee, or a seasonal employee. Eligibility may be further limited by the Component Plans or as set forth in Schedule A for certain Benefits.

An Employee is an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include (a) leased employees or individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as a common-law employee; (b) individuals who perform services for the Employer but who are paid by a temporary or other employment or staffing agency; or (c) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Q-4. When does participation begin and end in the Plan?

After you satisfy the eligibility requirements described in Q-3, you become a Participant by signing an individual Election Form/Salary Reduction Agreement (or completing any electronic enrollment materials). New employees' coverage under the Premium Payment Component will

be effective as of the effective date of coverage as set forth in each Component Plan. New employees' participation in the Health FSA and Dependent Care FSA will begin the first day of the month following 90 days of employment. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. You must complete the Election Form/Salary Reduction Agreement and return it to the Plan Administrator within the time period specified in the enrollment materials. An eligible Employee who fails to complete, sign, and file an Election Form/Salary Reduction Agreement as required will not be able to elect any benefits under the Plan until the next Open Enrollment Period (unless a Change in Election Event occurs, as explained in Q-7).

Employees who actually participate in the Plan are called "Participants." An Employee continues to participate in the Plan until (a) the Employee elects not to participate in the Plan; (b) the date on which the Employer determines that you have failed to make required salary reduction payments; (c) termination of the Plan; or (d) the last day of the month in which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, certain Employees may be able to continue eligibility in the Plan for certain periods. See Q-12.

See Q-8, Q-12 for information about how termination of participation affects your Benefits.

Q-6. What is the Open Enrollment Period and the Plan Year?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Plan by signing and returning an individual Election Form/Salary Reduction Agreement. You will be notified of the timing and duration of the Open Enrollment Period.

The Plan Year is the 12 months beginning on each January 1 and ending on December 31. The Plan Year is the same for the Plan, the Health FSA, and the Dependent Care FSA.

Q-7. Can I change my elections under the Plan during the Plan Year?

You generally cannot change your election to participate in the Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various Change in Election Events that are described in Attachment 1 (found at the end of this Summary).

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code (the Code), if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible

under applicable law. Such action by the Plan Administrator may include withholding any amounts due from your compensation.

Q-8. What happens if my employment ends during the Plan Year, or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan. The insured benefits will terminate as of the date specified in the Component Plans. See Q-12 for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-24. For reimbursement of expenses from the Dependent Care FSA Account after termination of employment, see Q-35.

If you are rehired within the same Plan Year and are eligible for the Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

Q-9. Will I pay any administrative costs under the Plan?

No. The cost of administering the Plan is paid entirely by the Employer.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits is denied?

Insurance Benefits. The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the plan). For more information about how to file a claim and for details regarding the medical and dental insurance companies' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Monmouth University Group Health Insurance Plan.

Claims Under the Plan, Health FSA, or Dependent Care FSA. If a claim for reimbursement under the Health FSA or Dependent Care FSA Components of the Plan is wholly or partially denied, or you are denied a benefit under the Plan (such as the ability to pay for insurance, Health FSA, or Dependent Care FSA Benefits on a pre-tax basis) due to an issue germane to

your coverage under the Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim under the Plan, Health FSA, or Dependent Care FSA is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Appeals under the Plan, Health FSA, or Dependent Care FSA will be reviewed and decided by the Plan Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Plan Administrator receives your request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on

review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under **ERISA §502(a)** (where applicable).

Claims Deadline. Unless otherwise provided under the Plan or required pursuant to applicable law, a claim for benefits under the Plan, Health FSA, or Dependent Care FSA must be made within one year after the date the expense was incurred that gives rise to the claim. You (or your designee, if applicable) are responsible for making sure this requirement is met.

Limitations Period for Filing Suit. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan, Health FSA, or Dependent Care FSA must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Q-12. What is Continuation Coverage, and how does it work?

COBRA. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." You will receive information about COBRA in a separate notice from the Employer. See the booklets for the insured Component Plans for information about COBRA continuation coverage under those plans.

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

Q-13. How will participating in the Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your medical, dental, and vision insurance, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all medical, dental, and vision insurance and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your medical, dental, and vision insurance and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by prepaying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to prepay in advance, you must make a special election before such compensation normally would be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your medical, dental, or vision insurance or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for nonpayment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as Dependent Care FSA Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as

agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be prepaid before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see Attachment 1 found at the end of this Summary).

Q-15. What are Premium Payment Benefits?

If you elect Premium Payment Benefits you will be able to pay for your share of contributions for insured benefits with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Q-16. How are my Premium Payment Benefits paid?

If you select one or more of the insurance plans available under the Plan, then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you elect coverage for a civil union partner, then the premiums for such coverage will be paid on an after-tax basis.

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Q-17. What are Health FSA Benefits?

A Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your medical insurance plan).

If you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into

account when determining benefits payable under any other plan. In the event that an expense is eligible for reimbursement under both the Health FSA and a health reimbursement arrangement, you must seek reimbursement and exhaust the funds in your Health FSA first before seeking reimbursement from the health reimbursement arrangement.

Q-18. What is my Health FSA Account?

If you elect Health FSA Benefits, then an account called a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-19. What are the maximum Health FSA Benefits that I may elect, and how are these benefits paid for?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to a maximum amount of $2,750 per Plan Year (which may be adjusted by the IRS in future years). You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer makes no contribution to your Health FSA Account.

Q-20. What is the Health FSA Grace Period?

The Grace Period is the two months and 15 days following the close of each Plan Year. You may be reimbursed for expenses incurred during the Grace Period. See Q-23.

Q-21. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any.

Note that only reasonable quantities of prescribed over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code §213(d) and have been prescribed. Stockpiling is not permitted.

Q-22. What are Medical Care Expenses that may be reimbursed from the Health FSA?

"Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d). However, expenses for medicines or drugs other than insulin will not qualify as Medical Care Expenses unless the medicine or drug has been prescribed. Thus, OTC medicines or drugs such as aspirin, antihistamines, and cough syrup must be prescribed in order to qualify as Medical Care Expenses; to be reimbursed for an OTC medicine or drug, you must provide documentation that the item was prescribed. In addition, as described above, only reasonable quantities of OTC drugs will be reimbursed from your Health FSA account in a single calendar month. The following list shows certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under IRS rules governing Health FSAs.

- EXCLUSIONS:
    - health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer);
    - long-term care services;
    - OTC medicines or drugs (other than insulin) that have not been prescribed;
    - any item that doesn't constitute "medical care" under **Code §213(d);** and
    - any item that isn't reimbursable under applicable regulations.
- Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-23. When must the Medical Care Expenses be incurred for the Health FSA?

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for a Plan Year, they must have been incurred during that Plan Year or the Grace Period. The Plan Year for the Health FSA is the same as the Plan Year for the Plan—it is the 12-month period beginning on January 1 and ending on December 31.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. You may not be reimbursed for any expenses incurred before the Health FSA or the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, or after a separation from service (except for continuation coverage). Expenses incurred during a subsequent Plan Year can only be reimbursed from your Health FSA Account for that Plan Year, except if incurred during the prior Plan Year's Grace Period.

Example: If you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

Q-24. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year or the Grace Period. If you have ceased to be eligible as a Participant, you will have until 90 days after the end of the Plan Year in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible. You will be notified in writing if any claim for benefits is denied.

However, with respect to Health FSA claims incurred during the 2019 Plan Year or corresponding Grace Period, the deadline for filing such a claim for reimbursement will be extended until 60 days after the end of the national emergency declared due to the 2019 Novel Coronavirus outbreak.

Medical Care Expenses incurred during a Plan Year will be reimbursed first from your unused amounts credited for that Plan Year. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense (as defined in Q-23) and that it is not being paid for or reimbursed from any other source.

If the Employer utilizes an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is available.

Q-25. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?

Yes. If the Medical Care Expenses that you incur during the Plan Year and Grace Period are less than the annual amount that you elected for Health FSA Benefits, you will forfeit any remaining amounts. This is called the use-or-lose rule under applicable tax laws. The difference between what you elected and the Medical Care Expenses that were reimbursed will be forfeited at the end of the time limits described in Q-26.

Q-26. What are the time limits that affect forfeiture of my Health FSA Benefits?

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted within 90 days following the end of the Plan Year for which the election was effective. Forfeited amounts will be used in a fashion that the Plan Administrator deems appropriate, consistent with applicable law or IRS guidance. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year or Grace Period in which the Medical Care Expense was incurred shall be forfeited and applied as described above. However, with respect to Health FSA claims incurred during the 2019 Plan Year or corresponding Grace Period, the deadline for filing such a claim for reimbursement will be extended until 60 days after the end of the national emergency declared due to the 2019 Novel Coronavirus outbreak.

Q-27. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit.

Example: To qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Medical Care Expenses submitted for reimbursement or withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-28. What are Dependent Care FSA Benefits?

A Dependent Care FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's Dependent Care FSA).

If you elect Dependent Care FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Q-29. What is my Dependent Care FSA Account?

If you elect Dependent Care FSA Benefits, an account called a "Dependent Care FSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions for such benefits that you have paid during the Plan Year. Your Dependent Care FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-30. What are the maximum and minimum Dependent Care FSA Benefits that I may elect under the Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the Dependent Care FSA, subject to the minimum reimbursement amount of $120 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual Dependent Care FSA contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in Dependent Care FSA Benefits, you'll pay for the benefits with a $3,000 salary reduction).

The amount of Dependent Care Expense reimbursement that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code §129 when your election is made. The $5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the Dependent Care FSA); (2) you furnish over half of the cost of maintaining the household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of the household; or
- you are single or the head of the household for federal income tax purposes.

If you are married and file a separate federal income tax return under circumstances other than those described above, then the maximum Dependent Care FSA Benefit that you may exclude from your income under Code §129 is $2,500 for a calendar year.

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income

may be less because of other limitations, as described in Q-33 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Q-31. How are my Dependent Care FSA Benefits paid for under the Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Dependent Care FSA Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your Dependent Care FSA Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

The Employer makes no contribution to your Dependent Care FSA Account.

Q-32. What amounts will be available for Dependent Care FSA reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your Dependent Care FSA Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. You may also be able to be reimbursed from unused amounts remaining in your Dependent Care FSA Account at the end of a Plan Year for Dependent Care Expenses incurred during the Grace Period following the end of the Plan Year (see Q-34).

Q-33. What are Dependent Care Expenses that may be reimbursed?

Dependent Care Expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
    - a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
    - your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

    - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).
- Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the child as a dependent. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.
- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your Dependent Care FSA Account.
- The expenses are incurred for services rendered after the date of your election to receive Dependent Care FSA Benefits and during the Plan Year to which the election applies.
- The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center—that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis—the center must comply with all applicable state and local laws.
- The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person whom you (or your Spouse) can claim as a dependent for federal income tax purposes. If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):
    - expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);
    - the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
    - expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided—e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Plan);
- the earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for more than one-half of such year), or (b) a full-time student); or
- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a Dependent Care FSA, the maximum amount that you and your Spouse together can exclude from income is $5,000.

Q-34. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your Dependent Care FSA Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year

for the Dependent Care FSA is the same as for the Plan. In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Dependent Care FSA Account at the end of a Plan Year for Dependent Care Expenses incurred during the Grace Period following the end of the Plan Year. Grace Periods will begin on January 1 and will end 2 months and 15 days later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. You may not be reimbursed for any expenses arising before the Dependent Care FSA or Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year or Grace Period, or after a separation from service (except as described in Q-35).

Example: If you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

In order to take advantage of the Grace Period, you must be a Participant in the Plan with Dependent Care FSA coverage that is in effect on the last day of the Plan Year to which the Grace Period relates (December 31). See Q-35 regarding certain rules that apply to claims for reimbursement for Dependent Care Expenses that are incurred during a Grace Period.

Q-35. What must I do to be reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Dependent Care FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the Dependent Care FSA Reimbursement Request Form. Further details about what must be provided are contained in the Dependent Care FSA Reimbursement Request Form.

If there are enough credits to your Dependent Care FSA Account, then you will be reimbursed for your eligible Dependent Care FSA Expenses within 30 days after the date you submitted the Dependent Care FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control). If a claim is for an amount larger than that remaining in your current Dependent Care FSA Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your Dependent Care FSA Account.

You will have until 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year or Grace Period. If you have ceased to be eligible as a Participant, you will have until 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses

incurred prior to the date you ceased to be eligible; you can also be reimbursed for expenses incurred in the month following your termination of participation if such month is in the current Plan Year and your claim is submitted by the 90-day deadline. You will be notified in writing if any claim for benefits is denied.

However, with respect to Dependent Care FSA claims incurred during the 2019 Plan Year or corresponding Grace Period, the deadline for filing such a claim for reimbursement will be extended until 60 days after the end of the national emergency declared due to the 2019 Novel Coronavirus outbreak.

The following additional rules will apply to Dependent Care Expenses that are incurred during a Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Dependent Care Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.
- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For this reason, if you also have Dependent Care FSA coverage for the new year, you may want to wait to submit Dependent Care Expenses you incur during the Grace Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- Expenses incurred during a Grace Period must still be submitted within 90 days following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from amounts remaining at the end of that Plan Year.

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in Q-34) and that it is not being paid for or reimbursed from any other source.

Q-36. Is there any risk of losing or forfeiting the amounts that I elect for Dependent Care FSA Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year or Grace Period are less than the annual amount that you elected for Dependent Care FSA Benefits, you will forfeit the rest of that amount in your Dependent Care FSA Account. (Carryovers are not available under the Dependent Care FSA.) This is called the use-or-lose rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year or Grace Period, even if amounts are still left in your Dependent Care FSA Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described in Q-37.

Q-37. What are the time limits that affect forfeiture of my Dependent Care FSA Benefits?

You will forfeit any amounts in your Dependent Care FSA Account that are not applied to Dependent Care FSA Benefits for any Plan Year by 90 days following the end of the Plan Year for which the election was effective. Forfeited amounts will be used in a fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Dependent Care FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year or Grace Period in which the Dependent Care Expense was incurred shall be forfeited and applied as described above. However, with respect to Dependent Care FSA claims incurred during the 2019 Plan Year or corresponding Grace Period, the deadline for filing such a claim for reimbursement will be extended until 60 days after the end of the national emergency declared due to the 2019 Novel Coronavirus outbreak.

Q-38. Will I be taxed on the Dependent Care FSA Benefits I receive?

Generally, you will not be taxed on your Dependent Care FSA Benefits, up to the limits set forth in Q-27. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Dependent Care FSA. The tax benefits that you receive depend on the validity of the claims that you submit.

Ultimately, it is your responsibility to determine whether any reimbursement under the Dependent Care FSA constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-39. What are my ERISA Rights?

The Plan and the Dependent Care FSA Component are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the medical, dental, and vision insurance Component Plans are governed by ERISA. Note: This Summary Plan Description does not describe the insured Component Plans. Consult the insured Component Plan documents and the separate Summary Plan Descriptions for the insured Component Plans.

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). 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 other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case ABC, Inc., as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue your medical, dental, and vision coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require ABC, Inc., as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court within one year after the date of a final decision on the claim.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Rights

Under HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies, including with regard to electronic PHI.

Q-40. What other general information should I know?

This Q-40 contains certain general information that you may need to know about the Plan.

General Plan Information

- Name: Monmouth University Cafeteria Plan
- Plan Number: 502
- Restatement Effective Date: January 1, 2020
- Plan Year: January 1 to December 31. Your Plan's records are maintained on this 12-month period of time.
- Type of Plan: Welfare plan providing health and accident insurance benefits, health FSA benefits, and Dependent Care FSA benefits.

Employer/Plan Sponsor Information

- Name and Address:

  Monmouth University

  400 Cedar Avenue

  West Long Branch, NJ 07764

- Federal employee tax identification number (EIN): 21-0634584.

Plan Administrator Information

- Name, address, and business telephone number:

  Monmouth University

  400 Cedar Avenue

  West Long Branch, NJ 07764

  Telephone Number: 732-571-3470

Funding Medium and Type of Plan Administration

- The Health FSA Component is a group health plan. The Health FSA and Dependent Care FSA Components are self-funded by the Employer and are contract administration plans. A third-party administrator processes claims for these Components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these Components. There is no trust for the Plan or any component.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Monmouth University

400 Cedar Avenue

West Long Branch, NJ 07764

Telephone Number: 732-571-3470

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

General Counsel

Monmouth University

400 Cedar Avenue

West Long Branch, NJ 07764

Qualified Medical Child Support Order

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

Amendment and Termination

Although the Employer intends to continue the Plan indefinitely, the Employer reserves the right to amend or terminate the Plan at any time and for any reason. If either of these actions is taken, you will be notified.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Insurance Plans Documents and Information

This Summary Plan Description does not describe the insured Component Plans. Consult the insured Component Plan documents and the separate Summary Plan Descriptions for the insured Component Plans for information about those plans.

Attachment 1

When Can I Change Elections Under the Plan During the Plan Year?

Participants can change their elections under the Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; and Changes in Coverage. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to insurance benefits if they are not permitted under the insurance plan, as applicable.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the medical insurance plan). If the change involves a loss of your Spouse's or Dependent's eligibility for insurance benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence *(Applies to insurance benefits, Health FSA, and Dependent Care FSA Benefits).* You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. Change in Status *(Applies to insurance benefits, Health FSA Benefits (as limited below), and Dependent Care FSA Benefits).* If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents: termination or commencement of employment; a strike or lockout; a commencement of

or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status—Other Requirements *(Applies to insurance benefits, Health FSA Benefits (as limited below), and Dependent Care FSA Benefits).* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.

Example: Assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the medical, dental, and vision plans and Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if

you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See the Plan Administrator for more information.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care FSA Benefits*. With respect to the Dependent Care FSA Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Dependent Care FSA; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

4. Special Enrollment Rights *(Applies Only to Medical Insurance Benefits).* In certain circumstances, enrollment for medical insurance benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the medical insurance benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders *(Applies to insurance benefits and Health FSA Benefits, but Not to Dependent Care FSA Benefits).* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the insurance benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid *(Applies to medical, dental, and vision insurance benefits and Health FSA Benefits (as limited below), but Not to Dependent Care FSA Benefits).* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the medical, dental, or vision insurance benefits and/or your Health FSA coverage may be canceled completely but not

reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage.

7. Change in Cost *(Applies to medical, dental, and vision insurance benefits and Dependent Care FSA Benefits (as limited below), but Not to Health FSA Benefits).* If the cost charged to you for your insurance benefits or Dependent Care FSA Benefits significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your contributions;
- revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;
- drop your coverage, but only if no other benefit package option provides similar coverage.

For these purposes, the Health FSA is not similar coverage with respect to the medical, dental, and vision insurance benefits; an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage. If the cost of medical, dental, or vision insurance benefits or Dependent Care FSA Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;
- if you are enrolled in another benefit package option (such as an HMO option under the medical insurance plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as a PPO option under the medical insurance plan); or
- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of insurance benefits; you generally will have to notify the Plan Administrator of increases or decreases in the cost of Dependent Care FSA benefits.

The change in cost provision applies to Dependent Care FSA Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage *(Applies to medical, dental, and vision insurance benefits, and Dependent Care FSA Benefits, but Not to Health FSA Benefits).* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your medical, dental, and vision insurance benefits or Dependent Care FSA Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the medical insurance benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your medical, dental, and vision insurance benefits or Dependent Care FSA Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in medical, dental, and vision insurance benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in Dependent Care FSA Benefits coverage.)

- *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

- *Dependent Care FSA Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service

provider. If you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider. And if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

9. Reduction of Hours *(Applies to Only to Medical Insurance Benefits).* If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, you may prospectively revoke your election for medical insurance plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the medical insurance plan coverage is revoked.

10. Exchange Enrollment *(Applies to Only to Medical Insurance Benefits).* If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for medical insurance plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the medical insurance plan coverage.

SCHEDULE A

The following Schedule, which may be amended from time to time by the Employer, specifies the Benefits and the Component Plans which set forth the terms, conditions and limitations of the Benefits offered to Participants. The periods of coverage for the Component Plans shall be the same as the Plan Year of the Plan, unless specified otherwise.

BENEFIT	PROVIDER	MAXIMUM LEVEL OF COVERAGE	EMPLOYER CONTRIBUTION
Medical	Horizon Blue Cross/Blue Shield of NJ	N/A	See Benefits Guide
Prescription	Horizon Blue Cross/Blue Shield of NJ; Prime Therapeutics	N/A	See Benefits Guide
Dental	Delta Dental NJ	N/A	See Benefits Guide
Vision	Horizon Blue Cross/Blue Shield of NJ; Davis Vision	N/A	See Benefits Guide
Basic Life & AD&D Insurance	Cigna	N/A	See Benefits Guide
Voluntary Supplemental Life Insurance	Cigna	N/A	N/A
Short Term Disability	Cigna	N/A	See Benefits Guide
Long Term Disability	Cigna	N/A	See Benefits Guide
Health FSA	Self-insured; administered by Discovery Benefits	$2,750 annually, subject to COLA increases	N/A
Dependent Care FSA	Self-insured; administered by Discovery Benefits	$5,000.00 annually $2,500.00 annually for married Participant filing separately	N/A
Medical Voluntary Incentive	N/A	See Medical Voluntary Financial Incentive Policy	See Medical Voluntary Financial Incentive Policy