CAPITAL HEALTH
RETIREMENT SAVINGS & INVESTMENT PLAN

SUMMARY PLAN DESCRIPTION

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INTRODUCTION TO YOUR PLAN

The Capital Health Retirement Savings & Investment Plan ("Plan") has been adopted as the retirement savings vehicle for Capital Health employees and is intended to provide you with the opportunity to save for retirement on a tax-deferred basis. This Plan is a type of defined contribution retirement plan commonly referred to as a "403(b) plan."

You have the opportunity to contribute to the Plan on a pre-tax basis through elective salary deferrals. In addition, Capital Health may provide you with the following employer retirement contributions if you are eligible to receive them:

- Employer base retirement contributions
- Employer transition retirement contributions
- Employer discretionary matching contributions

This Summary Plan Description ("SPD") contains valuable information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this SPD to get a better understanding of your rights and obligations under the Plan.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator. The name and address of the Plan Administrator can be found in the section of this SPD entitled "GENERAL INFORMATION ABOUT THE PLAN".

This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language under this SPD and the technical, precise language of the Plan document conflict, the Plan document always governs.

This SPD describes the current provisions of the Plan, as designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as ERISA (the Employee Retirement Income Security Act), the Internal Revenue Code and other federal and state laws that may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or the Department of Labor (DOL). Capital Health reserves the right to amend or terminate this Plan at any time. If the provisions of the Plan that are described in this SPD change, we will notify you.

PARTICIPATION IN THE PLAN

Am I eligible to participate in the Plan?

Provided you are not an Excluded Employee, you are eligible to participate in the Plan once you satisfy the Plan's eligibility conditions described in the next question. The following employees are Excluded Employees and are not eligible to participate in the Plan:

- Employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining are not eligible to receive any employer contributions unless the agreement expressly provides otherwise.

- Employees who are classified by Capital Health as per diem employees are not eligible to receive employer matching contributions.

- Employees of employers affiliated with Capital Health that have not specifically adopted the Plan in writing with the approval of Capital Health.

- Employees who are classified by Capital Health as independent contractors.

- Employees classified as residents are not eligible to receive any employer base retirement or transition retirement contributions.

When am I eligible to participate in the Plan?

You will be eligible to participate in the Plan on your date of hire. All employees are eligible to participate and make their own salary deferrals. However, this Plan excludes collective bargaining unit employees from receiving any employer contributions and per diem employees from receiving employer matching contributions. In addition, employees classified as residents are excluded from receiving any employer base retirement or transition retirement contributions.

When is my Entry Date?

Your entry date is the date you elect to make a salary deferral under the Plan. If you are eligible to receive any employer contributions, your entry date is your date of hire, or the date you later became eligible to receive such employer contributions.

What happens if I'm a participant, terminate employment and then I'm rehired?

If you are no longer an active participant because you terminated employment, and you are later rehired, then you are eligible to participate in the Plan as of your reemployment date, provided you are not an Excluded Employee as of your reemployment date (Excluded Employee is defined in the question *"Am I eligible to participate in the Plan?"* found in the "PARTICIPATION IN THE PLAN" section.)

CONTRIBUTIONS

What type of Plan is this?

This Plan is a type of defined contribution retirement plan commonly referred to as a 403(b) plan. As a participant under the Plan, you may elect to reduce your compensation by a specific percentage or a fixed dollar amount and have that amount contributed to the Plan on a pre-tax basis. You generally are not taxed on your salary reduction contributions until you withdraw those amounts from the Plan. In addition, Capital Health may make the following additional employer contributions to the Plan on your behalf if you are in a class of employees eligible to receive them:

- Employer base retirement contributions
- Employer transition retirement contributions
- Employer discretionary matching contributions

This section of the SPD describes the types of contributions that may be made to the Plan and how these monies will be allocated to your account to provide for your retirement benefit.

How much may I contribute to the Plan?

As a Participant, you may elect to defer a percentage or a fixed dollar amount of your compensation each year instead of receiving that amount in cash. The Plan Administrator will notify you of the maximum percentage you may defer. However, your total deferrals (less any "catch-up contributions") in any taxable year may not exceed a certain dollar limit which is set by law. The limit for 2012 is $17,000. After 2012, the dollar limit may be adjusted for cost-of-living adjustments.

In addition to the limit above, if you are projected to attain age 50 before the end of a calendar year, you may be eligible to make additional deferrals (called "catch-up contributions") for that year. If you exceed the deferral limit above, then any excess amount will be a "catch-up contribution." The maximum "catch-up contribution" that you may make in 2012 is $5,500. After 2012, the maximum may be adjusted for cost-of-living adjustments.

The amount you elect to defer, and any earnings on that amount, will not be subject to income tax until it is actually distributed to you. However, the amount you defer is counted as compensation for Social Security taxes.

You should also be aware that each separately stated annual dollar limit (the annual deferral limit and the "catch-up contribution" limit) is a separate aggregate limit that applies to all such similar salary reduction amounts and "catch-up contributions" you make under this Plan and any other cash or deferred arrangements (including tax-sheltered 403(b) annuity contracts, simplified employee pensions or other 401(k) plans of other employers). Generally, if an annual dollar limit is exceeded, then the excess must be included in your income for the year. For this reason, it is desirable to request in writing that any such excess salary reduction amounts and "catch-up contributions" be returned to you. If you fail to request such a return, you may be taxed a second time when the excess amount is ultimately distributed from the Plan.

You must decide which plan or arrangement you would like to have return the excess. If you decide that the excess should be distributed from this Plan, you should communicate this in writing to the Service Provider no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the dollar limit is exceeded in this Plan or any other plan maintained by us, then you will be deemed to have notified the Service Provider of the excess. The Service Provider will then return the excess deferral and any earnings to you by April 15th.

You will always be 100% vested (your ownership rights) in the amount you defer. This means that you will always be entitled to all amounts that you defer. This money will, however, be affected by any investment gains or losses. If there is a gain, the balance in your account would increase. If there was a loss, the balance in your account would decrease.

Distributions from your deferred account (including any offset of loans) are not permitted before age 59½ EXCEPT in the event of:

- death;
- total and permanent disability;
- severance from employment; or
- reasons of proven financial hardship. (For an explanation of financial hardship, see the question "*Can I withdraw money from my account in the event of financial hardship?*" found under "IN-SERVICE DISTRIBUTIONS".)

In the event you receive a hardship distribution from your deferrals to this Plan pursuant to your certification and agreement that certain conditions are satisfied, or any other plan maintained by Capital Health, you will not be allowed to make additional salary deferrals for a period of six months after you receive the distribution.

How often can I modify the amount I contribute?

Your pay will be reduced by the amount you elect to defer in accordance with the procedures established by the Plan Administrator. The procedures will require that you enter into a salary reduction agreement. You will be permitted to modify your election during the Plan Year by making a new salary reduction agreement and providing the Plan Administrator with written notice within a reasonable time before the pay period for which the modification is to be effective. You are also permitted to revoke your election any time during the Plan Year.

Will Capital Health contribute to the Plan?

Capital Health may contribute to the Plan the following amounts:

(a) The total amount of the salary reduction you elected to defer (including "catch-up contributions"). (See the question earlier in this section entitled "*How much may I contribute to the Plan?*")

(b) An employer discretionary matching contribution, if you are eligible to receive a matching contribution, equal to a percentage of your eligible compensation, based on your years of continuous service. If you have less than 15 years of continuous service, the matching contribution is 25% of the first 4% of your eligible compensation that you elect to defer. If you have 15 or more years of continuous service, the matching contribution is 50% of the first 4% of your eligible compensation that you elect to defer. The matching contribution is discretionary, which means that Capital Health may, at its discretion, suspend the matching contribution or change the amount that will be contributed. You will be notified of any changes.

You will be eligible to receive a matching contribution, if one is made, unless you are a per diem employee or a collective bargaining unit employee.

(c) Effective January 1, 2008, an employer base retirement contribution based on a percentage of your eligible compensation in accordance with the following schedule:

Years of Vesting Service at Beginning of Plan Year	Percentage of Contribution for Plan Year
0 – 4 years	2.5%
5 – 9 years	3.0%
10 – 14 years	4.0%
15+ years	5.0%

You will receive an employer base retirement contribution for a Plan Year unless you are classified as a resident or you are a collective bargaining unit employee. However, if you are not credited with at least 1,000 Hours of Service (see the section below entitled "HOURS OF SERVICE") by the end of the applicable Plan Year, any employer base retirement or transition retirement contribution credited to your account for such Plan Year will be forfeited.

(d) Effective January 1, 2008, an employer transition retirement contribution if, as of December 31, 2007, you

- were an active participant in the Capital Health Pension Plan,
- were age 55 or older, and
- had completed 15 Years of Vesting Service with Capital Health (see the section below entitled "RETIREMENT BENEFITS").

If you are eligible to receive an employer base retirement contribution as described in paragraph (c) above and you satisfy the eligibility requirements described in the preceding paragraph, you will receive an employer transition retirement contribution for a Plan Year equal to 1% of your eligible compensation if you are a Non-Highly Compensated Participant with respect to such Plan Year. However, if you are not credited with at least 1,000 Hours of Service for the applicable Plan Year, any employer transition retirement contribution credited to your account for such Plan Year will be forfeited.

A "Non-Highly Compensated Participant" is generally an employee that, for the year preceding the particular Plan Year in question, earned $110,000 (for 2011 and indexed for inflation thereafter) or less.

Any Non-Highly Compensated Participant who has a change in status and thus no longer qualifies as a Non-Highly Compensated Participant after December 31, 2007 will no longer be eligible to receive any employer

transition retirement contributions. This limitation will continue to apply to all future years regardless of future changes in Non-Highly Compensated Participant status.

Capital Health may suspend or change the percentage of any employer contribution with respect to any Plan Year.

How will Capital Health contributions be allocated to my account?

If you are eligible to receive any employer matching contributions, base retirement contributions or transition retirement contributions, Capital Health will allocate such contributions in the same manner as your elective salary reduction contributions.

If you do not enroll in the Plan with respect to making elective salary reduction contributions, any employer base retirement and transition retirement contributions you receive will be invested in the Plan's default fund, until such time as you make an investment election.

These contributions will vest (your ownership rights) in accordance with the applicable vesting schedule relating to each type of contribution. (See the question "*What is my vested interest in my account?*" found in the "RETIREMENT BENEFITS" section for an explanation of your ownership rights.)

In addition to the contributions made to your account by Capital Health, your account will be subject to investment earnings or losses that are tied to the performance of the funds in which your account is specifically invested.

What compensation is used to determine my Plan benefits?

For the purposes of the Plan, effective January 1, 2008 "compensation" means the total cash compensation paid to you by Capital Health as reported on IRS Form W-2, including your salary reduction contributions to any plan or arrangement maintained by Capital Health. Compensation shall exclude any hiring or referral bonus, severance pay, any non-performance related fringe benefits, or with respect to any Highly Compensated Participant, any special transition payments made by Capital Health outside of this Plan.

A "Highly Compensated Participant" is generally an employee that, for the year preceding the particular Plan Year in question, earned in excess of $110,000 (for 2011 and indexed for inflation thereafter). Any participant who was a Highly Compensated Participant with respect to any prior year will remain a Highly Compensated Participant for purposes of the special transition payment exclusion described in the preceding paragraph.

Your compensation will be recognized for benefit purposes from your date of entry into the Plan.

Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2012 is $250,000. This amount may be adjusted after 2012 for cost-of-living increases.

Is there a limit on how much can be contributed to my account each year?

Generally, the law imposes a maximum limit on the amount of contributions you may receive under the Plan. This limit applies to all contributions Capital Health makes on your behalf, all contributions (excluding any "catch-up contributions") you make to the Plan, and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings and any transfers/rollovers. Beginning in 2012, this total cannot exceed the lesser of $50,000 or 100% of your annual compensation. The dollar limit may be adjusted after 2012 for cost-of-living increases.

In addition, federal law requires the Plan to pass certain nondiscrimination tests. If you are within the group of employees classified as "highly compensated" under the Internal Revenue Code, all or a portion of matching contributions made on your behalf may need to be distributed to you as a result of a special nondiscrimination test. You are a highly compensated employee for this purpose in 2012 if your total compensation for 2011 exceeded $110,000. This compensation limit is subject to adjustment for increases in the cost of living.

May I "roll over" payments from other retirement plans or IRAs into this Plan?

At the discretion of the Plan Administrator, you may be permitted to deposit into the Plan distributions you have received from other plans and certain IRAs provided that such deposit does not jeopardize the exempt status of the Plan or create adverse tax consequences for Capital Health. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask your prior plan administrator to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from a prior plan. Alternatively, if you received a distribution from a prior plan, you may elect to deposit any amount eligible for rollover within 60 days of your receipt of the distribution. You should consult a qualified advisor to determine if a rollover is permitted and in your best interest.

Your rollover will be placed in a separate account called a "rollover account." You will always be 100% vested (your ownership rights) in your "rollover account." Rollover accounts will be affected by any investment gains or losses.

The Plan Administrator will inform you of the plans and IRAs from which you may make "rollover" contributions.

How is the money in the Plan invested?

You will be able to direct the investment of your entire interest in the Plan. A wide array of investment options are available. Investment option information is available through the web site at www.gwrs.com, or from the Plan Administrator. You can move all or a portion of your existing balances among investment options and change how your payroll contributions are invested. There are financial calculators and tools on the Web site that can help you determine which investment options might be best for you. In addition you can obtain other information from the Service Provider Representative on directed investments.

The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act). If the Plan complies with this Section, then the fiduciaries of the Plan, including Capital Health and the Service Provider, will be relieved of any legal liability for any losses that are the direct and necessary result of the investment directions that you give. Procedures must be followed in giving investment directions. If you fail to do so, then your investment directions need not be followed. When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your account does not share in the investment performance of other participants who have directed their own investments.

You are not required to direct investments. To the extent you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in a "qualified default investment alternative" established under the Plan by the Plan Administrator until such time as you provide the Plan Administrator with specific investment direction with respect to your account.

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance. Capital Health and the Service Provider will not provide investment advice or guarantee the performance of any investment you choose.

RETIREMENT BENEFITS

What benefits will I receive on my Normal Retirement Date?

You will be entitled to the employer contributions in your account under the Plan when you reach your Normal Retirement Age. However, actual payment of your benefits will, at your election, begin as soon as administratively feasible following your Normal Retirement Date. You must contact the Service Provider to apply for your retirement benefit. Your Normal Retirement Date is the date you reach your Normal Retirement Age. You will attain your Normal Retirement Age when you reach your 65th birthday.

What is my Late Retirement Date?

You may remain employed past your Normal Retirement Date and retire instead on your Late Retirement Date. Your Late Retirement Date is the date you choose to retire after first having reached your Normal Retirement Date. On your Late Retirement Date, you will be entitled to your account under the Plan. However, actual payment of your benefits will, at your election, begin as soon as administratively feasible following your Late Retirement Date. You must contact the Service Provider to receive a distribution of your account.

What happens if I leave Capital Health before I reach my Normal Retirement Age?

When your employment ends you will be entitled to receive only your vested percentage (your ownership rights) of your account balance.

You may elect to have your vested benefit distributed to you as soon as administratively feasible following your termination of employment. You must contact the Service Provider to receive a distribution of your account.

What is my vested interest in my account?

You are always 100% vested in your salary reduction and rollover amounts contributed to the Plan.

Your vested percentage (your ownership rights) in your employer contribution accounts is determined under the following schedules: You will always, however, be 100% vested upon your attainment of Normal Retirement Age while actively employed.

- Vesting schedule for employer matching contributions:

Periods of Service	Percentage
1 year	0%
2 years	100%

- Vesting schedule for employer base retirement contributions:

Years of Vesting	Percentage
1 year	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years	100%

- Vesting schedule for employer transition retirement contributions:

Years of Vesting	Percentage
1 year	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years	100%

Your vested benefit will normally be distributed to you or your beneficiary upon your death, disability or retirement.

How do I determine my whole year Periods of Service for employer matching contribution vesting purposes?

To earn a whole year Period of Service, you must be employed by Capital Health at any time after such whole year Period of Service measured from your initial employment commencement date. The Plan contains specific rules for crediting a Period of Service for vesting purposes. The Service Provider will track your service and will credit you with a Period of Service in accordance with the terms of the Plan. If you have any questions regarding your vesting service, you should contact the Plan Administrator.

How do I determine a Year of Vesting Service for employer base retirement and transition retirement contribution vesting purposes?

A Year of Vesting Service, for purposes of the base retirement contributions and the transition retirement contributions, will mean a Plan Year for which you are credited with at least 1,000 Hours of Service. Your Hours of Service are credited to the same Plan Year to which compensation for such hours is credited.

If you return to service with us, your Periods of Service and Years of Vesting Service before you left will count for the purpose of your vested percentage in future employer contributions made to the Plan, unless you incur 5 consecutive 1-Year Breaks in Service.

As a veteran, will my military service count as service with Capital Health?

If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with us. If you may be affected by this law, ask your Plan Administrator for further details.

What happens to my non-vested account balance if I'm rehired?

If you had no vested percentage in your employer account balance when you left, your account balance was forfeited. However, if you return to service with Capital Health before incurring 5 consecutive 1-Year Breaks in Service, your forfeited account balance will be restored unadjusted for any gains or losses.

If you were partially vested in your account balance when you left, the non-vested portion of your account balance will be forfeited on the **earlier** of:

- the distribution of your entire vested account balance, or
- when you incur 5 consecutive 1-Year Breaks in Service.

If you return to service with Capital Health before incurring 5 consecutive 1-Year Breaks in Service, the forfeited portion of your account will be restored unadjusted for any gains or losses.

You will have a Break in Service if you are not employed with Capital Health for a period of at least twelve consecutive months. However, if you are absent from work for certain leaves of absence such as maternity or paternity leave, the twelve month period beginning on the first anniversary of your first day of such absence will not constitute a Break in Service.

What happens to the non-vested portion of a terminated participant's account balance?

The non-vested portion of a terminated participant's account balance remains in the Plan and is called a forfeiture. Forfeitures will be used to reduce Capital Health’s contributions to the Plan.

DISABILITY BENEFITS

How is disability defined?

Under this Plan, you will be considered disabled if you are found to be totally and permanently disabled as determined by the Social Security Administration.

What happens if I become disabled?

If you become disabled while a participant, you will be entitled to all vested amounts credited to your account.

FORM OF BENEFIT PAYMENT

How will my benefits be paid?

You may elect to receive a distribution under one of the following methods:

- a single lump-sum payment; or
- monthly, quarterly, semi-annual or annual installments over a period of not more than your assumed life expectancy (or you and your beneficiary's assumed life expectancies); or
- purchase of a fixed annuity contract issued by the insurer providing for payments solely over a specified period of time (a “period certain”). The amount of any annuity you elect is determined by the amount that can be purchased with your account balance from an insurer.

The Plan Administrator will provide you with a written explanation of the available benefit distribution forms, the right to defer payment to your Normal Retirement Age and the consequences of the failure to do so no less than 30 days and no more than 180 days prior to your benefit commencement date.

May I delay the receipt of benefits?

Yes, you may delay the receipt of benefits. However, if you elect to delay the receipt of benefits, there are rules that generally require minimum payments to begin not later than the April 1st following the end of the year in which you reach age 70½ or, if later, terminate employment with Capital Health and all employers affiliated with Capital Health. You should contact the Service Provider if you feel you may be affected by these rules.

DEATH BENEFITS

What happens if I die while working for Capital Health?

If you die while working for Capital Health, all vested amounts credited to your account will be paid to your beneficiary.

Who is the beneficiary of my death benefit?

If you are married at the time of your death, your spouse will be the beneficiary of the death benefit, unless an election was made to change the beneficiary.

If you wish to designate a beneficiary other than your spouse as defined by current New Jersey law, your spouse must irrevocably consent to waive any right to the death benefit. Your spouse's consent must be in writing, be witnessed by a notary or a Plan representative and acknowledge the specific non-spouse beneficiary.

If you are married and your spouse is not named at least 100% primary beneficiary and you change your designation, then your spouse must consent to the change. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

If you are not married you may designate any beneficiary.

In the event no valid designation of beneficiary exists, or if the beneficiary is not alive at the time of your death, the death benefit will be paid to your estate.

Since your spouse has certain rights in the death benefit, you should immediately report any change in your marital status to the Plan Administrator.

How will the death benefit be paid to my beneficiary?

The death benefit will be paid to your beneficiary in one of the following methods as elected by the beneficiary (unless you elected one of the following forms of distribution for the death benefit prior to your death):

- a single lump-sum payment in cash; or
- monthly, quarterly, semi-annual or annual installments over a period to be determined by you or your beneficiary; or
- purchase of a fixed annuity contract issued by the insurer providing for payments solely over a specified period of time (a "period certain"). The amount of any annuity you elect is determined by the amount that can be purchased with your account balance from an insurer.

What happens if I'm a participant, terminate employment and die before receiving all of my benefits?

If you terminate employment with Capital Health and subsequently die, your beneficiary will be entitled to the vested percentage of your remaining account balance at the time of your death.

IN-SERVICE DISTRIBUTIONS

Can I withdraw money from my account while working?

Generally, you may only receive a distribution from the Plan prior to your termination of employment if you satisfy certain conditions.

You may be entitled to receive a pre-retirement distribution of your deferrals, rollover contributions and vested matching contributions if you have reached age 59½. However, any distribution will reduce the benefits you will receive at normal retirement. This distribution is made at your election. The Plan will not distribute employer base retirement or transition retirement contributions before your Normal Retirement Age, death or disability.

Also, the law restricts any pre-retirement distribution from certain accounts that are maintained for you under the Plan before you reach age 59½. These accounts are generally the ones set up to receive your salary reduction contributions.

Can I withdraw money from my account in the event of financial hardship?

Yes, if you satisfy certain conditions, the Service Provider may direct distribution up to 100% of your deferrals, rollover contributions and vested matching contributions in the event of an immediate and heavy financial need. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at normal retirement.

What constitutes a hardship?

A hardship distribution is allowed only on account of an immediate and heavy financial need, which is payment in the event of one of the following:

- Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) previously incurred by you, your spouse or your dependent or necessary for you, your spouse or your dependent to obtain medical care;

- Costs directly related to the purchase of your principal residence (excluding mortgage payments);

- Tuition, related educational fees, and room and board expenses for the next twelve months of post-secondary education for yourself, your spouse or dependent;

- Amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence;

- Payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents; or

- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code.

Are there any conditions to receiving a hardship distribution?

A distribution will be made from your account, but only if you certify and agree that **all** of the following conditions are satisfied:

- The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local taxes or penalties reasonably anticipated to result from the distribution;

- You have obtained all distributions, other than hardship distributions, and all nontaxable (at the time of the loan) loans currently available under all plans maintained by us; and

- Your contributions will be suspended for at least six months after your receipt of the hardship distribution.

In addition to these rules, there are restrictions placed on hardship distributions that are made from certain accounts. These accounts are generally the accounts that receive your salary reduction contributions. Any hardship distribution from these accounts will be limited, as of the date of distribution, to your total salary reduction contributions, reduced by the amount of any previous distributions made to you from these accounts. Ask your Service Provider Representative if you need further details.

HOURS OF SERVICE

What is an Hour of Service?

You will be credited with an Hour of Service for each hour for which you are paid or entitled to payment for the performance of duties for Capital Health or an employer who is affiliated with Capital Health. Your Hours of Service are credited to the same Plan Year to which compensation for such hours is credited.

LOANS

May I borrow money from the Plan?

Yes. You may request a participant loan using an application form provided by the Plan Administrator. Your ability to obtain a participant loan depends on several factors. The Plan Administrator will determine whether you satisfy these factors.

What are the loan rules and requirements?

There are various rules and requirements that apply for any loan, which are outlined in this question. In addition, Capital Health has established a written loan program that explains these requirements in more detail. You can request a copy of the loan program from the Plan Administrator. Generally, the rules for loans include the following:

- Loans are available to participants on a reasonably equivalent basis.

- Loans will only be permitted with respect to the portion of your account that is attributable to salary reduction contributions and vested employer matching contributions.

- All loans must be adequately secured. You must sign a promissory note along with a loan pledge. Generally, you must use your vested account balance as security for the loan. The maximum loan amount available is $50,000, or 50% of the vested account balance, whichever is less.

- You will be charged a reasonable rate of interest for any loan received from the Plan. Currently the interest rate is 2% over Prime Rate published in the Wall Street Journal on the first business day of the month before the loan is originated.

- If approved, your loan will provide for level amortization with payments to be made not less frequently than quarterly. Generally, the term of the loan may not exceed five years. However, if the loan is for the purchase of your principal residence, the Plan Administrator may permit a longer repayment period. Generally, the Plan Administrator will require that you repay your loan by agreeing to a payroll deduction. If you have an unpaid leave of absence or go on military leave while you have an outstanding loan, please contact the Service Provider to find out your repayment options.

- All loans will be considered a directed investment from your account under the Plan. All payments of principal and interest by you on a loan will be credited to your account.

- The amount the Plan may loan to you is limited by rules under the Internal Revenue Code. You may take a loan from the portion of your account attributable to your deferral contributions and vested matching contributions. Loans will be limited to the lesser of:

  - $50,000 or

  - one-half of the vested portion of your account balance attributable to your deferrals and employer matching contributions.

  Also, no loan in an amount less than $1,000 will be made nor will a loan be made if a prior loan is currently outstanding.

- If you fail to make payments when they are due under the loan, you will be considered to be "in default." The Plan will consider your loan to be in default if any scheduled loan repayment is not made by the end of the calendar quarter following the calendar quarter in which the missed payment was due. The Plan would then have authority to take all reasonable actions to collect the balance owing on the loan. This could include filing a lawsuit or foreclosing on the security for the loan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan, and could result in taxable income to you. In any event, your failure to repay a loan will reduce the benefit you would otherwise be entitled to from the Plan.

PROTECTED BENEFITS AND CLAIMS PROCEDURES

Is my benefit protected?

As a general rule, your interest in your account, including your vested interest, may not be alienated. This means your interest may not be sold, used as collateral for a loan (other than a Plan loan), given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your account.

Are there any exceptions to the general rule?

There is one exception to the general rule. The Plan Administrator must honor a "qualified domestic relations order." A "qualified domestic relations order" is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, child or other dependent. If a qualified domestic relations order is received by the Service

Provider, all or a portion of your benefits may be used to satisfy the obligation. The Service Provider will determine the validity of any domestic relations order received. You and your beneficiaries can obtain, without charge, a copy of the QUALIFIED DOMESTIC RELATIONS ORDER PROCEDURE from the Service Provider.

Can the Plan be amended?

Yes. Capital Health has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

Although Capital Health intends to maintain the Plan indefinitely, we reserve the right to terminate our involvement in the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. Capital Health will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. (See the question "*How will my benefits be paid?*" found in the "FORM OF BENEFIT PAYMENT" section) You will be notified of any modification or termination of the Plan.

How do I submit a claim for Plan benefits?

You can submit a claim for benefits by filling out the appropriate distribution form. You may obtain the forms from the Service Provider or the Service Provider's representative. Benefits will be paid to you and your beneficiaries after a claim has been filed. However, if you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Service Provider.

If the Service Provider determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Service Provider will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Service Provider, unless the Service Provider determines that special circumstances

require an extension of time for processing your claim. If the Service Provider determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90 day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, the Service Provider will provide you with written or electronic notification of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Service Provider determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Service Provider determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Service Provider notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

The Service Provider’s written or electronic notification of any adverse benefit determination must contain the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- Appropriate information as to the steps to be taken if you or your beneficiary wants to submit your claim for review.
- In the case of disability benefits:
    - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse

determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure in the next question.

What is the Claims Review Procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Plan Administrator. This procedure is described below:

1) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN OR ELECTRONIC NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

   HOWEVER, IF YOUR CLAIM IS FOR DISABILITY BENEFITS, YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

2) You may submit written comments, documents, records, and other information relating to your claim for benefits.

3) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

4) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the Claims Review Procedure above, if your claim is for disability benefits, then the Claims Review Procedure provides that:

- Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such

individual.

- In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. For this purpose, the "health care professional" will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

- Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

The Service Provider will provide you with written or electronic notification of the Plan's benefit determination on review. The Service Provider must provide you with notification of this denial within 60 days after the Service Provider's receipt of your written claim for review, unless the Service Provider determines that special circumstances require an extension of time for processing your claim. If the Service Provider determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60 day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. However, if your claim relates to disability benefits, then 45 days will apply instead of 60 days in the preceding sentences. In the case of an adverse benefit determination, the notification will set forth:

- The specific reason or reasons for the adverse determination.

- Reference to the specific Plan provisions on which the benefit determination is based.

- 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 your claim for benefits.

- In the case of disability benefits:

  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws, the claims procedure relating to those benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed. Ask the Plan Administrator if you have any questions regarding the proper person or entity to address claims.

If you have a claim for benefits that is denied upon review, in whole or part, you have up to two years from the date of such final adverse benefit determination to file a lawsuit. If the New Jersey statute of limitations for a similar type of claim runs out before the end of the two-year period described above, the New Jersey statute of limitations period is controlling. You should note that your suit brought in connection with the Plan must be brought in federal district court in Trenton, New Jersey.

What are my rights as a Plan participant?

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:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 pension benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the qualified domestic relations order (“QDRO”) procedures from the Plan Administrator.

If it should happen that the Plan's 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 if, for example, it finds your claim are frivolous.

What can I do if I have questions or my rights are violated?

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 the 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, 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.

PLAN EXPENSES

There are certain expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because they are directly attributable to you under the Plan. The Service Provider will inform you when there will be a charge (or charges) directly to your account.

Capital Health may, from time to time, change the manner in which expenses are allocated.

GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this section of the SPD.

General Plan Information

Capital Health Retirement Savings & Investment Plan is the name of the Plan.

We have assigned Plan Number 002 to the Plan.

The Plan's records are maintained on the basis of a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

Amounts contributed to the Plan may only be invested in a Funding Vehicle, or investment arrangement, authorized for 403(b) plans.

The Funding Vehicle used to hold contributions made to the Plan is an annuity contract issued by an insurance company and a custodial account.

The Plan will be governed by the laws of the State of New Jersey to the extent not preempted by ERISA.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) because Title IV of the Employee Retirement Income Security Act (ERISA) is not applicable to the Plan.

Employer Information

Your Employer's name, address and identification number are:

Capital Health System, Inc.
750 Brunswick Avenue
Trenton, New Jersey 08638
22-3548695

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted the Plan by making a written request to the Plan Administrator.

Plan Administrator Information

The Plan Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Plan Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation and directs the payment of your account at the appropriate time. The Plan Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan and your participation, you should contact the Plan Administrator. The Plan Administrator may designate another person or persons to perform some duties of the Plan Administrator.

The Plan Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Plan Administrator is conclusive and binding upon all persons.

The name, address and business telephone number of the Plan Administrator are:

Capital Health System, Inc.
c/o – Benefits Manager
446 Bellevue Avenue
Trenton, New Jersey 08618
(609) 394-4524

Service Provider Information

The contact information for the Service Provider is as follows:

Great West Retirement Services
PO Box 173764
Denver, CO 80217-3764
1-800-701-8255
GW Plan # 95812-01

Service of Legal Process

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

Capital Health System, Inc.
750 Brunswick Avenue
Trenton, New Jersey 08638

Service of legal process may also be made upon the Plan Administrator, attention General Counsel.