

**PRISMA HEALTH 401(A) PLAN
SUMMARY PLAN DESCRIPTION**

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PRISMA HEALTH 401(A) PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION TO YOUR PLAN

What kind of Plan is this?

PRISMA Health 401(a) Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This Plan is a type of qualified retirement plan commonly referred to as a 401(k) Plan. As a participant under the Plan, you may elect to contribute a portion of your compensation to the Plan.

What information does this Summary provide?

This Summary Plan Description ("SPD") contains 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.

In this SPD, the Employer has addressed the most common questions you may have regarding the Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator or other plan representative. The Plan Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name of the Plan Administrator can be found at the end of this SPD in the Article entitled "General Information about the Plan."

This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as some state laws. 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 Department of Labor (DOL). The Employer may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, the Employer will notify you.

ARTICLE I PARTICIPATION IN THE PLAN

How do I participate in the Plan?

To participate under the Plan, you must be an Eligible Employee. For this purpose, you are considered an Eligible Employee if you are an employee of any of the following employers once you have satisfied the eligibility requirements and reached your Entry Date, provided you are not an Excluded Employee.

- Prisma Health – Upstate
- Prisma Health
- Greenville Health Corporation
- Auxiliary to Greenville Hospital System
- Prisma Health – Midlands
- Prisma Health – University Medical Group
- Prisma Health Medical Group – Midlands
- PH ASC HR, LLC

The following describes Excluded Employees, if any, the eligibility requirements and Entry Dates that apply. You should contact the Plan Administrator if you have questions about the timing of your Plan participation.

All Contributions

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan. The Excluded Employees are:

- leased employees
- reclassified employees (a person the Employer does not treat as a common law employee on its payroll records, such as someone paid as an independent contractor or an out-sourced worker)

Additional Excluded Employee provisions

Self-Employed Individuals; Individuals employed by Greenville Health Authority (EIN 57-6007863) and Richland Memorial Hospital Leased (EIN 57-6000267). See the Plan Administrator for additional information if you are not sure if this affects you.

Eligibility Conditions. You will be eligible to participate in the Plan on your date of hire. However, you will actually enter the Plan once you reach the Entry Date.

Entry Date. Your Entry Date will be the date on which you satisfy the eligibility requirements.

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

If you are no longer a participant because of a termination of employment, and you are rehired, then you will be able to participate in the Plan on the date on which you are rehired if you are otherwise eligible to participate in the Plan.

ARTICLE II EMPLOYEE CONTRIBUTIONS

Does this Plan currently permit Elective Deferral contributions?

No, Elective Deferral contributions are not currently permitted to this Plan.

What are rollover contributions?

Rollover contributions. At the discretion of the Plan Administrator, if you are an eligible employee, you may be permitted to deposit into the Plan distributions you have received from other plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask the Plan Administrator or Trustee of the other plan or IRA 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 such plan. Alternatively, you may elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel to determine if a rollover is in your best interest.

Rollover account. Your rollover will be accounted for in a "rollover account." You will always be 100% vested in your "rollover account" (see the Article in this SPD entitled "Vesting"). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses.

Withdrawal of rollover contributions. You may withdraw the amounts in your "rollover account" at any time. You should see the Articles in this SPD entitled "Distributions Prior to Termination of Employment," "Distributions upon Termination of Employment," and "Distributions upon Death" for an explanation of how benefits (including your "rollover account") are paid from the Plan.

ARTICLE III EMPLOYER CONTRIBUTIONS

In addition to any deferrals you elect to make, the Employer will make additional contributions to the Plan. This Article describes Employer contributions that will be made to the Plan and how your share of the contributions is determined.

What is the Employer matching contribution and how is it allocated?

Discretionary Matching Contribution. The Employer may make a discretionary matching contribution with respect to elective deferral made under the PRISMA Health Retirement Savings Plan. Each year the Employer makes a discretionary matching contribution they are required to provide a separate notice no later than 60 days after the last match payment is made for the Plan Year.

If any related employers (related to the Employer by common ownership) elect to participate in the Plan, the employees of those related employers may become participants. If this occurs, the related employers' matching contributions to the Plan will be made based on the same formula as applies to the Employer. Any matching contribution made by a related employer will be allocated among all employees participating in the plan, regardless of which employer they work for.

Additional matching contribution provisions

Matching Contributions will apply to elective deferrals under the PRISMA Health Retirement Savings Plan. Each Employer may, at its discretion, make a Matching Contribution to the Plan on behalf of each eligible Participant for whom a Salary Deferral is made under the PRISMA Health Retirement Savings Plan not to exceed 100% of the Salary Deferrals made by the Participant to the PRISMA Health Retirement Savings Plan not to exceed 3% of Plan Compensation.

Allocation conditions. In order to share in the matching contribution for a Plan Year, you must satisfy the following conditions:

- If you are employed on the last day of the Plan Year, you will share regardless of the amount of service you complete during the Plan Year.

Waiver of allocation conditions

You will share in the matching contribution for the year you terminate employment regardless of the amount of service you complete during the Plan Year if you terminate on or following your death, disability or attainment of Normal Retirement Age.

What is the Employer nonelective contribution and how is it allocated?

Nonelective contribution. Each Plan Year, the Employer will make to the Plan a nonelective contribution equal to 3% of the compensation of all participants eligible to share in allocations. Your share of the contribution is determined below.

If any related employers (related to the Employer by common ownership) elect to participate in the Plan, the employees of those related employers may become participants. If this occurs, the related employers' nonelective contributions to the Plan will be made based on the same formula as applies to the Employer.

Allocation conditions. In order to share in the nonelective contribution you must satisfy the following conditions:

- You will share if you completed at least 1,000 Hours of Service during the Plan Year.

Your share of the contribution. The nonelective contribution will be "allocated" or divided among participants eligible to share in the contribution for the Plan Year.

Your share of the nonelective contribution will be determined by the formula for making that contribution.

If any related employers (related to the Employer by common ownership) elect to participate in the Plan, the employees of those related employers may become participants. If this occurs, the related employers' nonelective contributions to the Plan will be allocated based on the same method as applies to the Employer. Any nonelective contribution made by a related employer will be allocated among all employees participating in the plan, regardless of which employer they work for.

How is my service determined for allocation purposes?

Hour of Service. You will be credited with your actual Hours of Service for:

- (a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;
- (b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year) but credit will not exceed 501 hours of service for any single continuous period during which you perform no duties; and
- (c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

Service with another Employer. For allocation purposes, your Years of Service with any entity the Employer acquires will be counted, but only if you were an employee of the acquired entity at the time of the acquisition. See the Plan Administrator for details if you think you may be affected by this provision.

Service with another Employer. Notwithstanding any provision of the Plan to the contrary, an individual will be credited with service from a Predecessor Employer only if the individual was an employee of such Predecessor Employer on the date immediately preceding the acquisition and is employed by Prisma Health or an affiliate as of the date of the acquisition. For this purpose, an entity will be deemed acquired by Prisma Health only if Prisma Health or an affiliate acquires all or a portion of the entity's assets and patient charts.

What are forfeitures and how are they allocated?

Definition of forfeitures. In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the Employer makes to the Plan. This means that you will not be entitled to ("vested" in) all of the contributions until you have been employed with the Employer for a specified period of time (see the Article in this SPD entitled "Vesting"). If a participant terminates employment before being fully vested, then the non-vested portion of the terminated participant's account balance remains in the Plan and is called a forfeiture. Forfeitures may be used by the Plan for several purposes.

Allocation of forfeitures. Forfeitures will be allocated as follows:

- Forfeitures may be used to pay plan expenses or used to reduce any nonelective contribution.

ARTICLE IV COMPENSATION AND ACCOUNT BALANCE

What compensation is used to determine my Plan benefits?

All Contributions

Definition of compensation. Compensation is defined as your total compensation that is subject to income tax and paid to you by the Employer. The following describes the adjustments to compensation that apply for the contributions noted above.

Adjustments to compensation. The following adjustments to compensation will be made:

- elective deferrals to any other plan or arrangement (such as a cafeteria plan) will be included.
- reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits will be excluded.
- compensation paid while not a Participant in the component of the Plan for which compensation is being used will be excluded.
- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:
 - compensation paid for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential), or other similar payments that would have been made to you had you continued employment.

Additional compensation adjustment provisions

Non-cash compensation, gifts, severance pay, settlement payments, imputed income and payments designated by the Employer as COVID-19 related payments are excluded from Compensation. For pay dates beginning on and after August 26, 2022, financial assistance is excluded from Compensation.

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

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2023 is \$330,000. After 2023, the dollar limit may increase for cost-of-living adjustments.

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 that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. Beginning in 2023, this total cannot exceed the lesser of \$66,000 or 100% of your annual compensation (as limited under the previous question). After 2023, the dollar limit may increase for cost-of-living adjustments.

How is the money in the Plan invested?

The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan participants and their beneficiaries in accordance with the terms of this Plan. The trust fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

Participant direction of investments. You will be able to direct the investment of your entire interest in the Plan. The Plan Administrator will provide you with information on the investment choices available to you, the procedures for making investment elections, the frequency with which you can change your investment choices and other important information. You need to follow the procedures for making investment elections and you should carefully review the information provided to you before you give investment directions. If you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in accordance with the default investment alternatives established under the Plan. These default investments will be made in accordance with specific rules under which the fiduciaries of the Plan, including the Employer, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses resulting from the default investments. The Plan Administrator has or will provide you with a separate notice which details these default investments and your right to switch out of the default investment if you so desire.

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 the Employer, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses which 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. If you do not direct the investment of your applicable Plan accounts, your accounts will be invested in accordance with the default investment alternatives established under the Plan.

Earnings or losses. When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Participant-directed Account does not share in the investment performance of other participants who have directed their own investments. 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 and the Employer, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

Periodically, you will receive a benefit statement that provides information on your account balance and your investment returns. It is your responsibility to notify the Plan Administrator of any errors you see on any statements within 30 days after the statement is provided or made available to you.

Will Plan expenses be deducted from my account balance?

The Employer has elected to pay all plan related expenses except for certain expenses which are intrinsic to the value of the Trust assets such as brokerage commissions.

**ARTICLE V
VESTING**

What is my vested interest in my account?

In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the Employer makes to the Plan. This means that you will not be entitled to ("vested in") all of the contributions until you have been employed with the Employer for a specified period of time.

100% vested contributions. You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- rollover contributions
- matching contributions

Vesting schedules. Your "vested percentage" for certain Employer contributions is based on vesting Years of Service. This means at the time you stop working, your account balance attributable to contributions subject to a vesting schedule is multiplied by your vested percentage. The result, when added to the amounts that are always 100% vested as shown above, is your vested interest in the Plan, which is what you will actually receive from the Plan.

Nonelective Contributions

Your "vested percentage" in your account attributable to nonelective contributions is determined under the following schedule. You will always, however, be 100% vested in your nonelective contributions if you are employed on or after your Normal Retirement Age or if you terminate employment on account of your death, or if you terminate employment as a result of becoming disabled.

Vesting Schedule Nonelective Contributions	
Years of Service	Percentage
Less than 3	0%
3	100%

Additional vesting provisions

The vested interest in the Matching Contribution Accounts merged into this Plan from the Palmetto Health Matching Savings and 401(k) Plan of Participants who are not credited with at least one Hour of Service on or after December 27, 2019, shall be the percentage of the balance of such Account as of the applicable Valuation Date, based upon such Participant's Years of Service and upon the 6 Year graded vesting schedule. Notwithstanding any provision of the Plan to the contrary, the Employer Contribution for the 2020 Plan Year that was made on behalf of Participants who satisfied the applicable allocation conditions is 100% fully and immediately vested at all times.

Employer Contributions for Plan Years preceding and following the 2020 Plan Year are subject to the vesting schedule provided in this Plan.

How is my service determined for vesting purposes?

Year of Service. To earn a Year of Service, you must be credited with at least 1,000 Hours of Service during a Plan Year. The Plan contains specific rules for crediting Hours of Service for vesting purposes. The Plan Administrator will track your service and will credit you with a Year of Service for each Plan Year in which you are credited with the required Hours 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.

Hour of Service. You will be credited with your actual Hours of Service for:

- (a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;
- (b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year) but credit will not exceed 501 hours of service for any single continuous period during which you perform no duties; and
- (c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

What service is counted for vesting purposes?

Service with the Employer. In calculating your vested percentage, all service you perform for the Employer will generally be counted.

Service with another Employer. For vesting purposes, your Years of Service with any entity the Employer acquires will be counted, but only if you were an employee of the acquired entity at the time of the acquisition. See the Plan Administrator for details if you think you may be affected by this provision.

Additional service with another Employer provisions

Notwithstanding any provision of the Plan to the contrary, an individual will be credited with service from a Predecessor Employer only if the individual was an employee of such Predecessor Employer on the date immediately preceding the acquisition and is employed by Prisma Health or an affiliate as of the date of the acquisition. For this purpose, an entity will be deemed acquired by Prisma Health only if Prisma Health or an affiliate acquires all or a portion of the entity's assets and patient charts.

Military Service. 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 the Employer. If you may be affected by this law, ask the Plan Administrator for further details.

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

If you have no vested interest in the Plan when you leave, your account balance will be forfeited. However, if you are rehired before incurring five consecutive Breaks in Service, your account balance as of the date of your termination of employment will be restored, unadjusted for any gains or losses.

If you are partially vested in your account balance when you leave, the non-vested portion of your account balance will be forfeited on the earlier of the date:

- (a) of the distribution of your vested account balance, or
- (b) when you incur five consecutive Breaks in Service.

If you received a distribution of your vested account balance and are rehired, you may have the right to repay this distribution. If you repay the entire amount of the distribution, the Employer will restore your account balance with your forfeited amount. You must repay this distribution within five years from your date of rehire, or, if earlier, before you incur five consecutive Breaks in Service. If you were 100% vested when you left, you do not have the opportunity to repay your distribution.

What happens if the Plan becomes a "top-heavy plan"?

Top-heavy plan. A retirement plan that primarily benefits "key employees" is called a "top-heavy plan." Key employees are certain owners or officers of the Employer. A plan is generally a "top-heavy plan" when more than 60% of the plan assets are attributable to key employees. Each year, the Plan Administrator is responsible for determining whether the Plan is a "top-heavy plan."

Top-heavy rules. If the Plan becomes top-heavy in any Plan Year, then non-key employees may be entitled to certain "top-heavy minimum benefits," and other special rules will apply. These top-heavy rules include the following:

- The Employer may be required to make a contribution on your behalf in order to provide you with at least "top-heavy minimum benefits."
- If you are a participant in more than one Plan, you may not be entitled to "top-heavy minimum benefits" under both Plans.

ARTICLE VI DISTRIBUTIONS PRIOR TO TERMINATION OF EMPLOYMENT

Can I withdraw money from my account while working?

In-service distributions. You may be entitled to receive an in-service distribution. However, this distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement. This distribution is made at your election subject to possible administrative limitations on the frequency and actual timing of such distributions. You may withdraw amounts from your rollover contributions accounts at any time.

Conditions and Limitations. Generally you may receive a distribution from certain accounts prior to termination of employment provided you satisfy any of the following conditions:

- you have attained age 59 1/2. Satisfying this condition allows you to receive distributions from prior elective deferrals, matching contributions and nonelective contributions.
- you have incurred a financial hardship as described below.

Additional in-service distribution conditions:

Hardship distributions and in-service distributions upon attainment of age 59 1/2 shall be permitted from prior Salary Deferrals merged from the Baptist Easley Hospital Matching Savings and 401(k) Plan, prior Salary Deferrals merged from Greenville Health System 401(k) Savings Plan, and prior Salary Deferrals merged from the Palmetto Health Matching Savings and 401(k) Plan.

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

Hardship distributions. You may withdraw money on account of financial hardship if you satisfy certain conditions. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive upon termination of employment or other event entitling you to distribution of your account balance.

Qualifying expenses. A hardship distribution may be made to satisfy certain immediate and heavy financial needs that you have. A hardship distribution may only be made for payment of the following:

- Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) for you, your spouse or your dependents. This also includes medical expenses for the death beneficiary of your Plan account.
- 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 (12) months of post-secondary education for you, your spouse, your children or your dependents. This also includes such education expenses for the death beneficiary of your Plan account.
- 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 dependents. This also includes burial or funeral expenses for the death beneficiary of your Plan account.
- Expenses for the repair of damage to your principal residence (that would qualify for the casualty loss deduction under Internal Revenue Code Section 165) without regard to the limit on casualty losses that are deductible for income tax purposes under IRC 165(h).
- Expenses for disasters arising from federally declared disasters, such as your expenses and losses (including loss of income) attributable to that disaster, provided your principal residence or place of employment was in an area FEMA designates as qualifying for individual assistance.

For this purpose, your beneficiary is the person you designate under the Plan (or the Plan otherwise designates in the absence of your designation) to receive your death benefit and who is not necessarily your spouse or dependent.

Conditions. If you have any of the above expenses, a hardship distribution can only be made if you certify and agree that all of the following conditions are satisfied:

- (a) 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 income taxes or penalties reasonably anticipated to result from the distribution.
- (b) You have obtained all distributions, other than hardship distributions, currently available under all plans that the Employer maintains.
- (c) You certify (via a form for that purpose) that you have insufficient cash or other liquid assets reasonably available to satisfy the need.

Account restrictions. You may request a hardship distribution only from the vested portion of the following accounts:

- elective deferral accounts plus earnings
- qualified employer contributions

ARTICLE VII DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

When can I get money out of the Plan?

You may receive a distribution of the vested portion of some or all of your accounts in the Plan when you terminate employment with the Employer. The rules regarding the payment of death benefits to your beneficiary are described in the Article in this SPD entitled "Distributions upon Death."

As to the possibility of receiving a distribution while you are still employed with the Employer, see the Article in this SPD entitled "Distributions Prior to Termination of Employment."

Military Service. 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 the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Plan Administrator for further details.

Termination and distribution before Normal Retirement Age (or age 62 if later)

If your vested account balance exceeds \$5,000, your consent is required to distribute your account before you reach Normal Retirement Age (or age 62 if later). You may elect to have your vested account balance distributed to you as soon as administratively feasible following your termination of employment. (See the question entitled "In what method and form will my benefits be paid to me?" below for an explanation of the method of payment.)

If you terminate employment with a vested account balance exceeding \$5,000, you may elect to postpone your distribution until your "required beginning date" described below.

If your vested account balance does not exceed \$5,000, a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it, as soon as administratively feasible following your termination of employment. (See the question entitled "In what method and form will my benefits be paid to me?" below for an explanation of the method of payment.)

Amounts in your rollover account will be considered as part of your benefit in determining whether the \$5,000 threshold for timing of payments described above has been exceeded as well as for determining if the value of your vested account balance exceeds the \$5,000 threshold used to determine whether you must consent to a distribution.

Automatic Rollover of Certain Account Balances. If your vested account balance does not exceed \$5,000, the Plan will distribute your account without your consent. If the amount of the distribution exceeds \$1,000 (including any rollover contribution) and you do not elect to either receive or roll over the distribution, your distribution will be directly rolled over to an IRA. See "Automatic IRA Rollover of Certain Account Balances" in the Article in this SPD entitled "Tax Treatment of Distributions."

Distribution on or after Normal Retirement Age (or age 62 if later)

If you terminate employment with the Employer and will receive distribution on or after the later of age 62 or Normal Retirement Age, the Plan will distribute your account without your consent. The distribution will occur as soon as administratively feasible at the same time

described above for other pre-62/Normal Retirement Age distributions not requiring your consent, but in any event distribution will be made no later than 60 days after the end of the Plan Year in which you terminate employment. Notwithstanding the foregoing, if your vested account balance exceeds \$5,000 (including rollover contributions), you may elect to postpone your distribution until your "required beginning date" described below.

What is Normal Retirement Age and what is the significance of reaching Normal Retirement Age?

You will attain your Normal Retirement Age when you reach age 65.

You will become 100% vested in all of your accounts under the Plan (assuming you are not already fully vested) if you are employed on or after your Normal Retirement Age.

What happens if I terminate employment due to disability?

Definition of disability. Under the Plan, disability means The Participant can no longer continue in the service of the Employer because of a mental or physical condition that is likely to result in death or is expected to be of long-continued or indefinite duration. A Participant shall be considered Disabled only if it is determined by the Plan Administrator on the basis of medical evidence from a qualified physician, satisfactory to the Plan Administrator that the Participant is unable to perform usual and customary duties for the Employer..

Payment of benefits. If you terminate employment because you become disabled, you will become 100% vested in all of your accounts under the Plan and the Plan will distribute your account balance in the same manner as for any other non-death related termination.

In what method and form will my benefits be paid to me?

Termination and distribution before Normal Retirement Age (or age 62 if later)

If you terminate employment and will receive a distribution before the later of age 62 or Normal Retirement Age and your vested account balance does not exceed \$5,000, then your vested account balance may only be distributed to you in a single lump-sum payment in cash. If you are less than 100% vested in your account balance and have not incurred a forfeiture break in service, then your vested account balance may only be distributed to you in a single lump-sum payment in cash. A forfeiture break in service occurs after five consecutive one-year breaks in service. A break in service is a Plan Year in which you are not credited with at least 501 Hours of Service.

If you terminate employment and will receive a distribution before the later of age 62 and Normal Retirement Age and your vested account balance exceeds \$5,000, you may elect to receive a distribution of your vested account balance in:

- a single lump-sum payment in cash
- installments over a period of not more than your assumed life expectancy (or the assumed life expectancies of you and your beneficiary)

In determining whether your vested account balance exceeds the \$5,000 dollar threshold, "rollovers" (and any earnings allocable to "rollover" contributions) will be taken into account.

Distribution on or after Normal Retirement Age (or age 62 if later)

If you terminate employment and will receive distribution on or following the attainment of the later of age 62 or Normal Retirement Age, and your vested account balance (including rollovers) does not exceed \$5,000, you will receive distribution in the form of a single lump-sum payment in cash. If your balance exceeds \$5,000, you may elect to receive distribution as described above relating to termination before the later of age 62 and Normal Retirement Age. In determining whether your vested account balance exceeds the \$5,000 dollar threshold, "rollovers" (and any earnings allocable to "rollover" contributions) will be taken into account.

Required beginning date

As described above, you may delay the distribution of your vested account balance. However, if you elect to delay the distribution of your vested account balance, there are rules that require that certain minimum distributions be made from the Plan. If you are a 5% owner, distributions are required to begin not later than the April 1st following the end of the year in which you reach age 70 1/2 (if you were born before July 1, 1949) or age 72 (if you were born after June 30, 1949). If you are not a 5% owner, distributions are required to begin not later than the April 1st following the later of the end of the year in which you reach age 70 1/2 (if you were born before July 1, 1949) or age 72 (if you were born after June 30, 1949) or terminate employment. You should see the Plan Administrator if you think you may be affected by these rules.

**ARTICLE VIII
DISTRIBUTIONS UPON DEATH**

What happens if I die while working for the Employer?

If you die while still employed by the Employer, then 100% of your account balance will be used to provide your beneficiary with a death benefit.

Who is the beneficiary of my death benefit?

You may designate a beneficiary of your Plan account on a form provided to you for this purpose by the Plan Administrator. If you do not designate a beneficiary, your account will be distributed as described below under "No beneficiary designation." If you are married, your spouse has certain rights to the death benefit. You should immediately report any change in your marital status to the Plan Administrator.

Married Participant. If you are married at the time of your death, your spouse will be the beneficiary of the entire death benefit unless you designate in writing a different beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, 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.

Changes to designation.

If, with spousal consent as required, you have designated someone other than your spouse as beneficiary and now wish to change your designation, see the Plan Administrator for details. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Divorce. A divorce decree automatically revokes your designation of your spouse or former spouse as your beneficiary under the Plan unless a Qualified Domestic Relations Order provides otherwise. You should complete a form to make a new beneficiary designation if a divorce decree is issued. See the Plan Administrator for details if you think you may be affected by this provision.

Unmarried Participant. If you are not married, you may designate a beneficiary of your choosing.

No beneficiary designation. At the time of your death, if you have not designated a beneficiary or your beneficiary is not alive, the death benefit will be paid in the following order of priority to:

- (a) your surviving spouse
- (b) your children, including adopted children in equal shares (and if a child is not living, that child's share will be distributed to that child's living descendants)
- (c) your surviving parents, in equal shares
- (d) your estate

How will the death benefit be paid to my beneficiary?

Method/form of distribution. The form of payment of the death benefit will be in cash. If the death benefit payable to a beneficiary does not exceed \$5,000, then the benefit may only be paid as a lump sum. If the death benefit exceeds \$5,000, your beneficiary may elect to have the death benefit paid in:

- a single lump-sum payment in cash
- annual installments at least equal to the required minimum distribution amount

Timing of distribution. Payment of the death benefit must be made as soon as administratively feasible following your death.

When must the last payment be made to my beneficiary (required minimum distributions)?

The law generally restricts the ability of a retirement plan to be used as a method of deferring taxation for an unlimited period beyond the participant's life. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods. The application of these rules depends upon whether you die before or after your "required beginning date" as described above under "Required beginning date."

Death before required beginning date.

If you die before your required beginning date, distribution of your entire account must commence as soon as administratively feasible following your death and the determination of your beneficiary.

If your spouse is the sole beneficiary, your spouse may delay the start of payments until the year in which you would have attained age 70 1/2 (if you were born before July 1, 1949) or age 72 (if you were born after June 30, 1949).

Effective after December 31, 2019, the law now requires complete distributions to some beneficiaries of deceased participants within 10 (instead of 5) years after death. Generally, if your beneficiary is not a person, then your entire death benefit must be paid within five years after your death.

Distributions must generally begin by April 1 of the calendar year following the year you turn age 70 1/2 (if you were born before July 1, 1949) or age 72 (if you were born after June 30, 1949) or, in some cases, when you retire, if later. For more information, see IRS Publication 590-B.

Death after required beginning date.

If you die on or after your required beginning date, your entire account balance will be paid as soon as administratively feasible.

What happens if I terminate employment, commence payments and then die before receiving all of my benefits?

Your beneficiary will be entitled to your remaining vested interest in the Plan at the time of your death. See the Plan Administrator for more information regarding the timing and method of payments that apply to your beneficiary. The provision in the Plan providing for full vesting of your benefit upon death does not apply if you die after terminating employment.

ARTICLE IX TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59 1/2 could be subject to an additional 10% tax.

Can I elect a rollover to reduce or defer tax on my distribution?

Rollover or Direct Transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

(a) **60-day rollover.** You may roll over all or a portion of the distribution to an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, **MUST** be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct rollover option described in paragraph (b) below would be the better choice.

(b) **Direct rollover.** For most distributions, you may request that a direct transfer (sometimes referred to as a direct rollover) of all or a portion of a distribution be made to either an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the transfer. A direct transfer will generally result in no tax being due (unless you roll pre-tax accounts directly to a Roth IRA) until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Automatic IRA Rollover of Certain Account Balances

If a mandatory distribution is being made to you before the later of age 62 or Normal Retirement Age and your vested account balance does not exceed \$5,000 (including any rollover contribution), the Plan will distribute your vested portion in a single lump-sum payment in cash. However, you may elect whether to receive the distribution or to roll over the distribution to another retirement plan such as an individual retirement account ("IRA"). At the time of your termination of employment, the Plan Administrator will provide you with further information regarding your distribution rights. If the amount of the distribution exceeds \$1,000 (including any rollover contribution) and you do not elect either to receive or to roll over the distribution, the Plan automatically will roll over the distribution to an IRA. The IRA provider will invest the rollover funds in a type of investment designed to preserve principal and to provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund). The IRA provider will charge your account for any expenses associated with the establishment and maintenance of the IRA and with the IRA investments. In addition, your beneficiary

designation under the Plan, if any, will not apply to the rollover IRA. The IRA's terms will control in establishing a designated beneficiary under the IRA. You may transfer the IRA funds to any other IRA you choose. You may contact the Plan Administrator at the address and telephone number indicated in this SPD for further information regarding the Plan's automatic rollover provisions, the IRA provider and the fees and charges associated with the IRA.

Tax Notice. WHENEVER YOU RECEIVE A DISTRIBUTION THAT IS AN ELIGIBLE ROLLOVER DISTRIBUTION, THE PLAN ADMINISTRATOR WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH QUALIFIED TAX COUNSEL BEFORE MAKING A CHOICE.

ARTICLE X LOANS

Is it possible to borrow money from the Plan?

Yes. Loans are permitted in accordance with the Plan Loan Policy. If you wish to receive a copy of the Loan Policy, please contact the Plan Administrator.

ARTICLE XI PROTECTED BENEFITS AND CLAIMS PROCEDURES

Are my benefits protected?

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan (other than for a Plan loan), given away or otherwise transferred (except at death to your beneficiary). In addition, your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Are there any exceptions to the general rule?

There are three exceptions to this general rule. The Plan Administrator must honor a qualified domestic relations order (QDRO). A QDRO 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, children or other dependents. If a QDRO is received by the Plan Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Plan Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Plan Administrator, without charge, a copy of the procedure used by the Plan Administrator to determine whether a qualified domestic relations order is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, the Plan Administrator can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

The last exception applies to Federal tax levies and judgments. The Federal government is able to use your interest in the Plan to enforce a Federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

Can the Employer amend the Plan?

The Employer 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 the Employer intends to maintain the Plan indefinitely, the Employer reserves the right to terminate 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. The Employer will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. You will be notified if the Plan is terminated.

How do I submit a claim for Plan benefits?

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution will be considered a claim for benefits. In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than by a third party such as the Social Security Administration), then you must also include with your claim sufficient evidence to enable the Plan Administrator to make a determination on whether you are disabled.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If the Plan Administrator 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.

For purposes of the claims procedures described below, "you" refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary). A document, record, or other information will be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described below. If applicable, the Plan will not assert that you failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and you are not precluded from challenging the decision under ERISA §501(a) or other applicable law.

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 Plan Administrator 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 (except as provided below for disability claims) after the receipt of your claim by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator 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, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then instead of the above, the initial claim must be resolved within 45 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Plan. The Plan will notify you of the extension prior to the end of the 45-day period. If, after extending the time period for a first period of 30 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period. Appropriate notice will be provided to you before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues. You will have 45 days from the date of receipt of the Plan Administrator's notice to provide the information required.

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining your appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the determination was based.
- (c) 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.
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(e) In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration, then the following additional information will be provided:

- (i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - The views you presented to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;
 - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
 - A disability determination made by the Social Security Administration and presented by you to the Plan.
- (ii) Either the internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or other criteria do not exist.
- (iii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.
- (iv) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

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.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS (EXCEPT AS PROVIDED BELOW FOR DISABILITY CLAIMS) AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

IF YOUR CLAIM IS FOR DISABILITY BENEFITS AND DISABILITY IS DETERMINED BY THE PLAN ADMINISTRATOR (RATHER THAN A THIRD PARTY SUCH AS THE SOCIAL SECURITY ADMINISTRATION), THEN INSTEAD OF THE ABOVE, YOU MUST FILE THE CLAIM FOR REVIEW NOT LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION. IN THE CASE OF AN ADVERSE BENEFIT DETERMINATION REGARDING A RESCISSION OF COVERAGE, YOU MUST REQUEST A REVIEW WITHIN 90 DAYS OF THE NOTICE.

- (b) You may submit written comments, documents, records, and other information relating to your claim for benefits.
- (c) 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.
- (d) 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 and disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then:

- (a) 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.
- (b) If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

- (c) 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.
- (d) If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.
- (e) Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the Plan Administrator must provide you with a copy of the rationale at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow you time to respond.

The Plan Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. The Plan Administrator must provide you with notification of this denial within 60 days (45 days with respect to claims relating to the determination of disability benefits) after the Plan Administrator's receipt of your written claim for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. In such a case, you will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify you of the determination on review no later than 120 days (or 90 days with respect to claims relating to the determination of disability benefits).

The Plan Administrator will provide written or electronic notification to you in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

- (a) The specific reason or reasons for the adverse determination.
- (b) Reference to the specific Plan provisions on which the benefit determination was based.
- (c) 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.
- (d) In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration):
 - (i) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.
 - (ii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.
 - (iii) A statement of your right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to your right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

If the Plan offers voluntary appeal procedures, a description of those procedures and your right to obtain sufficient information about those procedures upon request to enable you to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of your right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on you as part of the voluntary appeal. A decision whether to use the voluntary appeal process will have no effect on your rights to any other Plan benefits.

- (iv) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by the claimant to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
 - a disability determination made by the Social Security Administration and presented by you to the Plan.

If you have a claim for benefits which is denied, then you may file suit in a state or Federal court. However, in order to do so, you must file the suit no later than 180 days after the date of the Plan Administrator's final determination denying your claim.

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 are entitled to:

- (a) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including collective bargaining agreements and insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and insurance contracts, if any, 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.
- (c) 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 the 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 Plan's 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, for example, it finds your claim is 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.

ARTICLE XII 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 Article.

Plan Name

The full name of the Plan is PRISMA Health 401(a) Plan.

Plan Number

The Employer has assigned Plan Number 003 to your Plan.

Plan Effective Dates

This Plan was originally effective on January 1, 1999. The amended and restated provisions of the Plan become effective on January 1, 2022.

Other Plan Information

Valuations of the Plan assets are made annually on the last day of the Plan Year. The Plan Administrator also may require more frequent valuations.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year ends on December 31st.

The Plan will be governed by the laws of the state of the Employer's principal place of business to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

Service of legal process may be made upon the Employer. Service of legal process may also be made upon the Trustee or Plan Administrator.

Employer Information

The Employer's name, address, business telephone number and identification number are:

Prisma Health - Upstate
300 E. McBee Avenue
Greenville, South Carolina 29601
864-797-7907
81-1723202

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 or your participation, you should contact the Plan Administrator. The Plan Administrator may designate other parties 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's Administrator are:

Defined Contribution Retirement Plans Administrative Committee of Prisma Health and Affiliated Organizations
300 E. McBee Avenue
Greenville, South Carolina 29601
864-797-7907

Plan Trustee Information and Plan Funding Medium

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan assets (unless the investment of assets is subject to Participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a trust fund, the Plan Administrator separately accounts for each Participant's interest in the Plan. If there is more than one Trustee, they will collectively be referred to as Trustee throughout this Summary Plan Description.

The Plan's Trustee is:

Prudential Bank & Trust Company FSB

The contact information for the Plan's Trustee is:

30 Scranton Office Park
Scranton, PA 18507