SUMMARY PLAN DESCRIPTION
FOR

PRISMA HEALTH 401(a) PLAN

January 1, 2021

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PRISMA Health 401(a) Plan
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ARTICLE 1
INTRODUCTION

Prisma Health - Upstate has adopted the PRISMA Health 401(a) Plan (f/k/a Greenville Health System 401(a) Plan) (the "Plan") to help its employees save for retirement. If you are an employee of Prisma Health - Upstate, you may be entitled to participate in the Plan, provided you satisfy the conditions for participation as set forth in the Plan and described in this Summary Plan Description. In addition, if you are an employee of any of the following Employers, you also may be entitled to participate in the PRISMA Health 401(a) Plan.

- Prisma Health
- Greenville Health Corporation
- GHS Partners in Health, Inc.
- Partners in Health- Rural Health
- Auxiliary to Greenville Hospital System
- Health Sciences Center, LLC
- Prisma Health – Midlands
- PH-USC Medical Group

Additionally, the following plans were previously merged into the Plan:

- Baptist Easley Hospital Matching Savings and 401(k) Plan (effective as of February 1, 2019)
- Greenville Health System 401(k) Savings Plan (effective as of March 1, 2019)
- Palmetto Health Matching Savings and 401(k) Plan (effective as of December 27, 2019)

Any participant account balance which was held under one of these merged plans was transferred to this Plan as of the effective date of the merger.

This Summary Plan Description ("SPD") is designed to help you understand the retirement benefits provided under the Plan and your rights and obligations with respect to the Plan. This SPD contains a summary of the major features of the Plan, including the conditions you must satisfy to participate under the Plan, the amount of benefits you are entitled to as a Plan participant, when you may receive distributions from the Plan, and other valuable information you should know to understand your Plan benefits. We encourage you to read this SPD and contact the Plan Administrator if you have any questions regarding your rights and obligations under the Plan. (See Article 2 below for the name and address of the Plan Administrator.)

This SPD does not replace the formal Plan document, which contains all of the legal and technical requirements applicable to the Plan. However, this SPD does attempt to explain the Plan language in a non-technical manner that will help you understand your retirement benefits. If the non-technical language under this SPD and the technical, legal language under the Plan document conflict, the Plan document always governs. If you have any questions regarding the provisions contained in this SPD or if you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan document may be amended or modified due to changes in law, to comply with pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL), or due to other circumstances. If the Plan is amended or modified in a way that changes the provisions under this SPD, you will be notified of such changes.

This SPD does not create any contractual rights to employment nor does it guarantee the right to receive benefits under the Plan. Benefits are payable under the Plan only to individuals who have satisfied all of the conditions under the Plan document for receiving benefits.

ARTICLE 2
GENERAL PLAN INFORMATION AND KEY DEFINITIONS

This Article 2 contains information regarding the day-to-day administration of the Plan as well as the definition of key terms used throughout this SPD.

Plan Name: PRISMA Health 401(a) Plan

Plan Number: 003

Employer:

Name: Prisma Health - Upstate
Address: 300 E. McBee Ave.
Greenville, South Carolina 29601
Telephone number: (864) 797-7970
Employer Identification Number (EIN): 81-1723202

In addition to the Employer listed above, this Plan has also been adopted by the following Participating Employer(s):

- Prisma Health (EIN# 82-2595551)
- Greenville Health Corporation (EIN# 57-0835816)
- GHS Partners in Health, Inc. (EIN# 57-1004971)
- Partners in Health- Rural Health (EIN# 58-2293838)
- Auxiliary to Greenville Hospital System (EIN# 57-0355625)
- Health Sciences Center, LLC (EIN# 37-1848756)
- Prisma Health – Midlands (EIN# 58-2296052)
- PH-USC Medical Group (EIN# 47-1345819)

Predecessor Employer(s):

In applying the eligibility and allocation rules under Article 5 and the vesting rules under Article 7, all service you perform with us is taken into account. In addition, service with "predecessor" employers may be credited as follows:

- An individual will be credited with service from a "predecessor" employer that has been acquired by Prisma Health or an affiliate on or after January 1, 2020, provided that 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.

Thus, if you performed any service for such predecessor employers, you may receive credit for such service under this Plan. Please contact the Plan Administrator if you have questions about the type of service that may be taken into account with such predecessor employers.

Plan Administrator:

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, provides you with forms necessary to request a distribution from the Plan, and directs the payment of your vested benefits when required

under the Plan. The Plan Administrator may designate another person or persons to perform the duties of the Plan Administrator. The Plan Administrator or its delegate, as the case may be, has full discretionary authority to interpret the Plan, including the authority to resolve ambiguities in the Plan document and to interpret the Plan's terms, including who is eligible to participate under the Plan and the benefit rights of participants and beneficiaries. All interpretations, constructions and determinations of the Plan Administrator or its delegate shall be final and binding on all persons, unless found by a court of competent jurisdiction to be arbitrary and capricious. The Plan Administrator also will allow you to review the formal Plan document and other materials related to the Plan.

The Employer has designated the following person or persons to take on the responsibilities of Plan Administrator. If you have any questions about the Plan or your benefits under the Plan, you should contact the Plan Administrator.

Name: Defined Contribution Retirement Plans Administrative Committee of Prisma Health and Affiliate Organizations
Address: 300 E. McBee Ave.
City, State, Zip Code: Greenville, South Carolina, 29601
Telephone number: (864) 797-7970

Trustee:

All amounts contributed to the Plan are held by the Plan Trustee in a qualified Trust. The Trustee is responsible for the safekeeping of the trust funds and must fulfill all Trustee duties in a prudent manner and in the best interest of you and your beneficiaries. The Employer has designated a separate Trustee to hold the assets under the Plan. The trust established on behalf of the Plan will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

The following is the name and address of the Plan Trustee:

- **Name:** Prudential Bank & Trust Company FSB
  Address: 30 Scranton Office Park, Scranton, PA, 18507

Service of Legal Process:

Service of legal process may be made upon the Employer. In addition, service of legal process may be made upon the Plan Trustee or Plan Administrator.

Effective Date of Plan:

This Plan is an amendment and restatement of the Prisma Health – Upstate 401(a) Plan (f/k/a Greenville Health System 401(a) Plan), effective as of December 27, 2019. The Plan was originally adopted, effective January 1, 1999. The Palmetto Health Matching Savings and 401(k) Plan was merged into the Plan effective as of December 27, 2019. Unless designated otherwise, the provisions of the Plan as set forth in this SPD are effective as of January 1, 2021.

Plan Year:

Many of the provisions of the Plan are applied on the basis of the Plan Year. For this purpose, effective as of January 1, 2020, the Plan Year is the calendar year running from January 1 – December 31. The Plan previously had a short Plan Year running from October 1, 2019 to December 31, 2019.

Plan Compensation:

In applying the contribution formulas under the Plan (as described in Article 4 below), your contributions may be determined based on Plan Compensation earned during the Plan Year. In determining Plan Compensation, no amount will be taken into account to the extent such compensation exceeds the compensation dollar limit set forth under IRS rules. For 2021, the compensation dollar limit is $290,000.

Thus, for Plan Years beginning in 2021, no contribution may be made under the Plan with respect to Plan Compensation above $290,000. For subsequent Plan Years, the contribution dollar limit may be adjusted for cost-of-living increases. Note that the compensation dollar limit described above does not apply to Salary Deferrals contributed to the Plan.

"Plan Compensation" generally includes your total taxable wages or salary. Plan Compensation also includes post-severance payments of compensation for services and payments related to unused accrued leave that you would have been entitled to use if you had continued employment, provided that such amounts are paid by no later than the end of the year in which you terminate employment or more than 2½ months following termination of employment, if later; any other severance payments, including post-severance payments from an unfunded deferred compensation plan, are excluded from Plan Compensation. Unless provided otherwise, Plan Compensation also includes any pre-tax salary reduction contributions you may make under any other plans we may maintain, which may include any pre-tax contributions you make under a medical reimbursement plan or “cafeteria” plan. Further, for purposes of determining contributions under the Plan, certain amounts may be excluded from Plan Compensation based on the type of contributions being determined:

- **Matching Contributions.** In determining the amount of Matching Contributions that will be made on behalf of Participants under the Plan, the following amounts are excluded in determining Plan Compensation:
  - Extraordinary remuneration under the following pay codes of the Employer: Ben-advance, Comp Add – Clinical Advisor, Comp Add – Clinical Mentor, Employee Discount, Employee Reimbursement, Fee for Service, Severance-BiWeekly, Severance-Lump Sum, and Tuition Non-Taxable.
  - Imputed Income and any payments designated as COVID-19 related payments

- **Employer Contributions.** In determining the amount of Employer Contributions that will be made on behalf of Participants under the Plan, the following amounts are excluded in determining Plan Compensation.
  - Any payments designated as COVID-19 related payments.

For purposes of determining Plan Compensation, only compensation you earn while you are a participant in the Plan will be taken into account. Thus, any compensation you earn while you are not eligible to participate in the Plan will not be considered in determining Plan Compensation.

Normal Retirement Age:

You will reach Normal Retirement Age under the Plan when you turn age 65.

ARTICLE 3
DESCRIPTION OF PLAN

This Plan is a defined contribution plan, which is intended to qualify under Section 401(a) of the Internal Revenue Code. As a defined contribution plan, it is not covered under Title IV of ERISA and, therefore, benefits are not insured by the Pension Benefit Guaranty Corporation.

ARTICLE 4
PLAN CONTRIBUTIONS

The Plan provides for the contributions listed below. Article 5 discusses the requirements you must satisfy to receive the contributions described in this Article 4. Article 7 describes the vesting rules applicable to your plan benefits. Special rules also may apply if you leave employment to enter qualified military service. See your Plan Administrator if you have questions regarding the rules that apply if you are on military leave.

Matching Contributions

We may make Matching Contributions to this Plan based on the amount of contributions you make under the following plan(s) we maintain: PRISMA Health Retirement Savings Plan. If you satisfy all of the eligibility requirements described in Article 5 below for Matching Contributions and you make contributions to such plan(s), you may be entitled to receive an allocation of Matching Contributions under this Plan.

Matching Contributions will be contributed to your Matching Contribution account under the Plan at such time as we deem appropriate. Matching Contributions may be contributed during the Plan Year or after the Plan Year ends. Any Matching Contributions we make will be made in accordance with the following Matching Contribution formula.

- **Discretionary Matching Contribution (based on deferrals made to another 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 up to 3% of Plan Compensation. We will decide each year how much, if any, we wish to make as a Matching Contribution. Since this Matching Contribution is discretionary, we may decide not to make a Matching Contribution.

Limit on Matching Contributions. In addition to the overall limit on total contributions described in Article 6 below, the Plan imposes special limits on the amount a participant may receive as a Matching Contribution under the Plan for the Plan Year.

- **Limit on Eligible Contributions.** In determining the amount of Matching Contributions we will make on your behalf, we may decide not to match all of your contributions. For example, we may decide in our discretion not to match contributions you make above a specified percentage of compensation or above a specified dollar amount. We will inform you if we intend to limit the contributions that will be eligible for a Matching Contribution.

Employer Contributions

We are authorized under the Plan to make Employer Contributions on behalf of our employees. In order to receive an Employer Contribution, you must satisfy all of the eligibility requirements described in Article 5 below for Employer Contributions. If you do not satisfy all of the conditions for receiving an Employer Contribution, you will not share in an allocation of such Employer Contributions for the period for which you do not satisfy the eligibility requirements.

Employer Contribution Formula. Employer Contributions will be contributed to your Employer Contribution account under the Plan at such time as we deem appropriate. Generally, Employer Contributions may be contributed during the Plan Year or after the Plan Year ends. Any Employer Contributions we make will be made in accordance with the following Employer Contribution formula.

- **Fixed Employer Contribution formula.** We will make a contribution to the Plan on behalf of eligible participants equal to 3% of Plan Compensation. Such contribution will be placed in an account under the Plan on your behalf, provided you satisfy the eligibility conditions described in Article 5 below. We retain the right to amend the Plan to reduce or eliminate this contribution. If we amend the Plan to reduce or eliminate this fixed contribution, you will be notified of such change. (See Article 11 below for more information regarding Plan amendments.)

Special Employer Contribution – QNEC. In addition to any other contributions authorized under the Plan, we may decide to make a special discretionary contribution called a Qualified Nonelective Employer Contribution (QNEC). If you receive a QNEC contribution, you will automatically be 100% vested in that QNEC contribution. If we decide to make a QNEC to the Plan, we will make such contribution on behalf of eligible participants who are nonhighly compensated employees (as determined under the Plan).

Any QNEC contributed to the Plan will be allocated as a uniform percentage of Plan Compensation or as a uniform dollar amount. Alternatively, we may make the QNEC first to Employees with the lowest Plan

Compensation. To receive an allocation of QNECs, you must satisfy the minimum age and service conditions described in Article 5 below for Salary Deferrals. However, you do not have to satisfy any other allocation conditions to receive an allocation of QNECs under the Plan. Thus, for example, you do not have to be employed at the end of the year or work a specific number of hours of service to receive a QNEC contribution under the Plan.

Top Heavy Benefits

A plan that primarily benefits key employees is called a top heavy plan. For this purpose, key employees are defined as certain owners of an employer and officers with a specified level of compensation. A plan is generally a top heavy plan when more than 60% of all account balances under the plan are attributable to key employees. The Plan Administrator will determine each year whether the plan is a top heavy plan.

If the Plan becomes top heavy in any Plan Year, non-key employees who are eligible to receive a top heavy contribution under the Plan generally will receive a minimum contribution equal to the lesser of 3% of Plan Compensation or the highest percentage provided to any key employee (as defined in the Plan). This minimum contribution may be different if the Employer maintains another qualified plan. For this purpose, any Employer Contributions and Matching Contributions may be taken into account in determining whether the top heavy rules are satisfied. In applying the top heavy rules, any eligible non-key employee who is employed at the end of the year is entitled to the top heavy minimum, regardless how many hours the employee works during the year. The Plan Administrator will advise you if the Plan ever becomes top heavy.

Rollover Contributions

If you have an account balance in another qualified retirement plan or an IRA, you may move those amounts into this Plan, without incurring any tax liability, by means of a “rollover” contribution. You may not rollover Roth contributions from another qualified plan to this Plan since Roth contributions are not permitted under this Plan. Rollovers are not permitted from a Roth IRA. You are always 100% vested in any amounts you contribute to the Plan as a rollover from another qualified plan or IRA. 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 under the Plan.

You may accomplish a rollover in one of two ways. You may ask your prior plan administrator or trustee to directly rollover to this Plan all or a portion of any amount which you are entitled to receive as a distribution from your prior plan. Alternatively, if you receive a distribution from your prior plan, you may elect to deposit into this plan any amount eligible for rollover within 60 days of your receipt of the distribution. Any rollover to the Plan will be credited to your Rollover Contribution Account. See Article 8 below for a description of the distribution provisions applicable to rollover contributions.

Generally, the Plan will accept a rollover contribution from another qualified retirement plan or IRA. The Plan Administrator may adopt separate procedures limiting the type of rollover contributions it will accept. For example, the Plan Administrator may impose restrictions on the acceptance of after-tax contributions or Salary Deferrals (including Roth Deferrals) or may restrict rollovers from particular types of plans. In addition, the Plan Administrator may, in its discretion, accept rollover contributions from Employees who are not currently participants in the Plan. You also must be a current Employee to make a Rollover Contribution to the Plan. Any procedures affecting the ability to make Rollover Contributions to the Plan will not be applied in a discriminatory manner.

If you have questions about whether you can rollover a prior plan distribution, please contact the Plan Administrator or other designated Plan representative.

ARTICLE 5
ELIGIBILITY REQUIREMENTS

This Article sets forth the requirements you must satisfy to participate under the Plan. To qualify as a participant under the Plan, you must:

- be an Eligible Employee
- satisfy the Plan's minimum age and service conditions and
- satisfy any allocation conditions required under the Plan.

Eligible Employee

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, provided you are not otherwise excluded from the Plan.

- Prisma Health - Upstate
- Prisma Health
- Greenville Health Corporation
- GHS Partners in Health, Inc.
- Partners in Health- Rural Health
- Auxiliary to Greenville Hospital System
- Health Sciences Center, LLC
- Prisma Health – Midlands
- PH-USC Medical Group

Excluded Employees. For purposes of determining whether you are an Eligible Employee, the Plan excludes from participation certain designated employees. If you fall under any of the excluded employee categories, you will not be eligible to receive the designated Plan contribution until such time as you no longer fall into an excluded employee category. [See below for a discussion of your rights upon changing to or from an excluded employee classification.]

The following describes the types of employees that are not eligible to participate with respect to the different types of contributions authorized under the Plan.

Matching Contributions. The following employees are not eligible to receive Matching Contributions under the Plan. If you fall under one of the following classes of employees, you will not share in any Matching Contributions under the Plan.

- Leased employees
- Self-Employed Individuals
- Individuals employed by Greenville Health Authority (57-6007863) and Richland Memorial Hospital Leased (57-6000276)

Employer Contributions. The following employees are not eligible to receive Employer Contributions under the Plan. If you fall under one of the following classes of employees, you will not share in any Employer Contributions we make to the Plan.

- Leased employees
- Self-Employed Individuals
- Individuals employed by Greenville Health Authority (57-6007863) and Richland Memorial Hospital Leased (57-6000276)

Minimum Age and Service Requirements

In order to participate in the Plan, you must satisfy certain age and service conditions under the Plan. Different minimum age and service requirements apply depending on the type of contributions made under the Plan.

- **Matching Contributions.** In order to receive Matching Contributions under the Plan, you must be an Eligible Employee and you must satisfy the following minimum age and service requirements.
  - **Minimum age requirement.** There is no minimum age requirement in order to receive Matching Contributions under the Plan.
  - **Minimum service requirement.** There is no minimum service requirement in order to receive Matching Contributions under the Plan. Thus, you will be able to receive Matching Contributions (provided you are an Eligible Employee) as of the first Entry Date following your date of employment (or the date you satisfy any minimum age requirement described above).
- **Employer Contributions.** In order to receive Employer Contributions under the Plan, you must be an Eligible Employee and you must satisfy the following minimum age and service requirements.
  - **Minimum age requirement.** There is no minimum age requirement in order to receive Employer Contributions under the Plan.
  - **Minimum service requirement.** There is no minimum service requirement in order to receive Employer Contributions under the Plan. Thus, you will be able to receive Employer Contributions (provided you are an Eligible Employee) as of the first Entry Date following your date of employment (or the date you satisfy any minimum age requirement described above).

Entry Date. Once you have satisfied the eligibility conditions described above, you will be eligible to participate under the Plan on your Entry Date. For this purpose, you will have a different Entry Date based on the type of contributions under the Plan.

- **Matching Contributions.** Your Entry Date applicable to Matching Contributions is your date of employment. Thus, you will be eligible to receive Matching Contributions immediately upon your date of hire, provided you are an Eligible Employee.
- **Employer Contributions.** Your Entry Date applicable to Employer Contributions is your date of employment. Thus, you will be eligible to receive Employer Contributions under the Plan immediately upon your date of hire, provided you are an Eligible Employee.

Crediting eligibility service. In determining whether you satisfy any minimum age or service conditions under the Plan, all service you perform during the year is counted. In addition, if you go on a maternity or paternity leave of absence (including a leave of absence under the Family Medical Leave Act) or a military leave of absence, you may receive credit for service during your period of absence for certain purposes under the Plan. You should contact the Plan Administrator to determine the effect of a maternity/paternity or military leave of absence on your eligibility to participate under the Plan. See Article 2 for a description of "predecessor" employers for whom service may be credited for eligibility purposes under the Plan.

Eligibility upon rehire or change in employment status. If you terminate employment after satisfying the minimum age and service requirements under the Plan and you are subsequently rehired as an Eligible Employee, you will enter the Plan on the later of your rehire date or your Entry Date. If you terminate employment prior to satisfying the minimum age and service requirements, and you are subsequently rehired, you will have to re-satisfy the eligibility requirements in order to participate under the Plan.

If you are not an Eligible Employee on your Entry Date, but you subsequently change status to an eligible class of Employee, you will be eligible to enter the Plan immediately (provided you have already satisfied the minimum age and service requirements). If you are an Eligible Employee and subsequently become ineligible to participate in the Plan, all contributions under the Plan will cease as of the date you become ineligible to participate. However, all service earned while you are employed, including service earned while you are ineligible, will be counted when calculating your vested percentage in your account balance.

Allocation Conditions

If you are an Eligible Employee and have satisfied the minimum age and service requirements described above, you are entitled to share in the contributions described in Article 4, provided you satisfy the allocation conditions described below.

Matching Contributions. You will be entitled to share in any Matching Contributions we make to the Plan only if you satisfy the following allocation conditions. Thus, even if you satisfy the eligibility conditions described above, you will not receive any Matching Contributions if you do not satisfy the following allocation conditions.

- You must be employed on the last day of the Plan Year to receive a Matching Contribution for such Plan Year.

If you are not employed on the last day of the Plan Year, you will not be entitled to a Matching Contribution, even if you have satisfied all other conditions for receiving the Matching Contribution.

- **Exceptions to allocation conditions.** The allocation conditions described above do not apply if:
  - you die during the Plan Year
  - you terminate employment as a result of a disability
  - you terminate employment after attaining Normal Retirement Age

Employer Contributions. You will be entitled to share in any Employer Contributions we make to the Plan only if you satisfy the following allocation conditions. Thus, even if you satisfy the eligibility conditions described above, you will not receive any Employer Contributions if you do not satisfy the following allocation conditions.

- You must work at least 1000 hours during the Plan Year.

Thus, you will not be entitled to an Employer Contribution for the Plan Year unless you work at least 1000 hours during the Plan Year.

ARTICLE 6
LIMIT ON CONTRIBUTIONS

The IRS imposes limits on the amount of contributions you may receive under this Plan, as described below.

IRS limit on total contributions under the Plan. The IRS imposes a maximum limit on the total amount of contributions you may receive under this Plan. This limit applies to all contributions we make on your behalf, all contributions you contribute to the Plan, and any forfeitures allocated to any of your accounts during the year. Under this limit, the total of all contributions under the Plan cannot exceed a specific dollar amount or 100% of your annual compensation, whichever is less. For 2021, the specific dollar limit is $58,000. (For years after 2021, this amount may be increased for inflation.) For purposes of applying the 100% of compensation limit, your annual compensation includes all taxable compensation, increased for any pre-tax contributions you may make to any other plan we may maintain, such as a cafeteria health plan.

Example: Suppose in 2021 you earn compensation of $50,000. The maximum amount of contributions you may receive under the Plan for 2021 is $50,000 (the lesser of $58,000 or 100% of $50,000).

ARTICLE 7
DETERMINATION OF VESTED BENEFIT

Vested account balance. When you take a distribution of your benefits under the Plan, you are only entitled to withdraw your *vested* account balance. For this purpose, your *vested* account balance is the amount held under the Plan on your behalf for which you have earned an ownership interest. You earn an ownership

interest in your Plan benefits if you have earned enough service with us to become *vested* based on the Plan's vesting schedule. If you terminate employment before you become fully vested in any of your Plan benefits, those non-vested amounts may be forfeited. (See below for a discussion of the forfeiture rules that apply if you terminate with a non-vested benefit under the Plan.)

The following describes the vesting schedule applicable to contributions under the Plan.

- **Matching Contributions.** You are always 100% vested in your Matching Contributions (except as provided under "Special vesting rules", below). Thus, you have complete ownership rights to your Matching Contributions immediately after such amounts are contributed to the Plan on your behalf.

- **Employer Contributions.** You become *vested* in your Employer Contributions account under a "3-year cliff vesting schedule." Under this vesting schedule, you will have a complete ownership interest in your Employer Contributions once you have completed three (3) Years of Vesting Service. Prior to the completion of three Years of Vesting Service, you have no ownership interest in your Employer Contribution account.

- **Other contributions.** In addition, certain special contributions that are made to the Plan on your behalf will always be 100% vested. If any of these special contributions are made to the Plan, you will always have an immediate ownership interest in such contributions. Examples of special contributions that may be made to the Plan include:
  - Qualified Nonelective Employer Contributions (QNECs)
  - Rollover Contributions

Top heavy contributions. If you are eligible to receive top heavy contributions (as described in Article 4 above), the vesting schedule with respect to such contributions will be the same as applies for Employer Contributions.

Special vesting rules – Palmetto Health Matching Savings and 401(k) Plan. If you had a Matching Contribution account under the Palmetto Health Matching Savings and 401(k) Plan that was merged into this Plan, but you did not complete at least one Hour of Service on or after December 27, 2019, your vested percentage in the account will be the percentage of the balance of such account as of the applicable Valuation Date, based upon your Years of Service and the 6-year graded vesting schedule from the Palmetto Health Matching Savings and 401(k) Plan.

Protection of vested benefit. Once you are vested in your benefits under the Plan, you have an ownership right to those amounts. While you may not be able to immediately withdraw your vested benefits from the Plan due to the distribution restrictions described under Article 8 below, you generally will never lose your right to those vested amounts. However, it is possible that your benefits under the Plan will decrease as a result of investment losses. If your benefits decrease because of investment losses, you will only be entitled to the vested amount in your account at the time of distribution.

Exception to vesting schedule. The above vesting schedule no longer applies once you reach Normal Retirement Age under the Plan. Thus, if you are still employed with us at Normal Retirement Age, you will automatically become 100% vested in all contributions under the Plan. You also will be fully vested in your entire account balance (regardless of the Plan's vesting schedule) if the plan is terminated. In addition, if you die or become disabled while you are still employed with us, you will automatically become 100% vested.

Years of Vesting Service. To calculate your vested benefit under the Plan, your Years of Vesting Service are used to determine where you are on the vesting schedule. You will be credited with a Year of Vesting Service for each year in which you work at least 1,000 hours. The Plan Administrator will track your service and will calculate your years of service in accordance with the Plan requirements. Additionally, a special Year of Vesting Service will apply for the short Plan Year running from October 1, 2019 to December 31, 2019.

In calculating your Years of Vesting Service, all of your service with us is taken into account, including service you may have earned before the Plan was adopted. Additionally, Years of Vesting Service credited under the Palmetto Health Matching Savings and 401(k) Plan shall be takin into account for determining Years of Vesting Service in this Plan.

Forfeiture of nonvested benefits. If you terminate employment before you become fully vested in your Plan benefits, you will be entitled to receive a distribution of your *vested* benefits under the Plan. Your non-vested benefits will be *forfeited* as described below. You are not entitled to receive a distribution of your non-vested benefits.

If you terminate employment at a time when you are only partially-vested (or totally non-vested) in any of your Plan benefits, how the Plan treats your non-vested balance will depend on whether you take a distribution when you terminate employment.

- **Forfeiture upon distribution.** If you take a distribution of your entire vested benefit when you terminate employment, your non-vested benefit will be forfeited in accordance with the terms of the Plan. If you are totally non-vested in any contributions we made on your behalf, you will be deemed to receive a distribution for purposes of applying these forfeiture rules.

  - **Buy-back of forfeited benefits upon reemployment.** If you take a distribution of your entire vested benefit when you terminate employment, and as a result, some (or all) of your Plan benefits are forfeited, you have the right to repay the distributed amount to the Plan if you are rehired prior to incurring five consecutive Breaks in Service (as defined under "Forfeiture upon five consecutive Breaks in Service" below). If you repay the total amount of your distribution back to the Plan, we will restore the amount of your non-vested benefit which was forfeited as a result of that distribution. Please contact the Plan Administrator if you wish to buy-back prior benefits under the Plan. The Plan Administrator will inform you of the amount you must repay to buy-back your prior forfeited benefit.

  - **Timing of buy-back.** For us to restore your forfeited benefits, you must make repayment to the Plan no later than five years following your reemployment date. If you received a "deemed" distribution because you were totally non-vested, your non-vested benefit will automatically be restored within a reasonable time following your reemployment, provided you have not incurred five consecutive Breaks in Service prior to your reemployment.

- **Forfeiture upon five consecutive Breaks in Service.** Depending on the value of your vested benefits, you may be able to keep your benefits in the Plan when you terminate employment. If you do not take a distribution of your entire vested benefit when you terminate employment, your non-vested benefit will remain in your account until you have incurred five consecutive Breaks in Service, at which time your non-vested benefit will be forfeited in accordance with the terms of the Plan. For this purpose, you will have a Break in Service for each year in which you work less than 501 hours. Your vested benefits will not be forfeited under this forfeiture rule. If you have any questions regarding the application of these rules, you should contact the Plan Administrator.

Treatment of forfeited benefits. If any of your benefits are forfeited, we may decide in our discretion how to use those forfeited amounts. For example, we may use such forfeitures to pay Plan expenses. If any forfeitures are not used to pay Plan expenses, such forfeitures may be allocated as additional Employer contributions or we may use the forfeitures to reduce other Employer Contributions under the Plan. We will determine each year the amount of any forfeitures for such year and will use those forfeitures in the Plan Year for which the forfeiture occurs or in the following Plan Year.

ARTICLE 8
PLAN DISTRIBUTIONS

The Plan contains detailed rules regarding when you can receive a distribution of your benefits from the Plan. As discussed in Article 7 above, if you qualify for a Plan distribution, you will only receive your vested benefits. This Article 8 describes when you may request a distribution and the tax effects of such a distribution.

Distribution upon termination of employment. When you terminate employment, you may be entitled to a distribution from the Plan. The availability of a distribution will depend on the amount of your vested account balance.

- **Vested account balance in excess of $5,000.** If your total vested account balance exceeds $5,000 as of the distribution date, you may receive a distribution from the Plan as soon as administratively feasible following your termination of employment. If you do not consent to a distribution of your vested account balance, your balance will remain in the Plan. If you receive a distribution of your vested benefits when you are only partially-vested in your Plan benefits, your non-vested benefits will be forfeited.

  You may elect to take your distribution in any of the following forms. In addition, in certain rare cases, you may be entitled to a distribution in the form of a joint and survivor annuity. Prior to receiving a distribution from the Plan, you will receive a distribution package that will describe the distribution options that are available to you. If you have any questions regarding your distribution options under the Plan, please contact the Plan Administrator.

  - **Lump sum.** You may elect to take a distribution of your entire vested account balance in a lump sum. In addition, if permitted by the Plan Administrator, you may take a partial distribution of a portion of your vested account upon termination of employment. If you take a lump sum distribution, you may elect to rollover all (or any portion) of your distribution to an IRA or to another qualified plan. See the *Special Tax Notice*, which you may obtain from the Plan Administrator, for more information regarding your ability to rollover your plan distribution.
  - **Installment payments.** You may elect to receive a distribution in the form of a series of installment payments. If you elect distribution in the form of installments, your vested benefit will be paid out in equal annual installments over a set number of years. If the installment period is 10 years or greater, you may not rollover any of the installment payments into an IRA or into another qualified plan. The Plan Administrator will provide you with forms necessary to elect an installment distribution under the Plan.

- **Vested account balance of $5,000 or less.** If your total vested account balance under the Plan is $5,000 or less as of the distribution date, you will be eligible to receive a distribution of your entire vested account balance in a lump sum as soon as administratively feasible following your termination of employment. If you receive a distribution of your vested benefits when you are partially-vested in your Plan benefits, your non-vested benefits will be forfeited.

  You may elect to receive your distribution in cash or you may elect to rollover your distribution to an IRA or to another qualified plan. If your total vested account balance under the Plan is between $1,000 and $5,000 as of the distribution date and you do not consent to a distribution of your vested account balance, your vested benefit automatically will be rolled over to an IRA selected by the Plan Administrator. If your total vested account balance exceeds $5,000, no distribution will be made from the Plan without your consent. If your total vested account balance is $1,000 or less as of the distribution date, your entire vested benefit will be distributed to you in a lump sum, even if you do not consent to a distribution.

  If your benefit is automatically rolled over to an IRA selected by the Plan Administrator, such amounts will be invested in a manner designed to preserve principal and provide a reasonable rate of return. Common types of investment vehicles that may be used include money market accounts, certificates of deposit or stable value funds. Reasonable expenses may be charged against the IRA account for expenses associated with the establishment and maintenance of the IRA. Any such

expenses will be no greater than similar fees charged for other IRAs maintained by the IRA provider. For further information regarding the automatic rollover requirements, including further information regarding the IRA provider and the applicable fees and expenses associated with the automatic rollover IRA, please contact the Plan Administrator or other designated Plan representative.

In-service distributions. You may withdraw vested amounts from the Plan while you are still employed with us, but only if you satisfy the Plan's requirements for in-service distributions. Different in-service distribution options apply depending on the type of contribution being withdrawn from the Plan.

- **Matching Contributions.** You may withdraw amounts attributable to Matching Contributions while you are still employed upon any of the following events:
  - You are at least age 59½ at the time of the distribution.
- **Employer Contributions.** You may withdraw amounts attributable to Employer Contributions while you are still employed upon any of the following events:
  - You are at least age 59½ at the time of the distribution.
- **Rollover Contributions.** If you have rolled money into this Plan from another qualified plan or IRA, you may take an in-service distribution of your Rollover Contribution account at any time.
- **Qualified Nonelective Contributions (QNECs).** Generally, the same in-service distribution options as apply to Salary Deferrals also apply to QNECs under the Plan. However, QNECs may not be withdrawn on account of hardship.
- **Prior Salary Deferral Contributions merged from the Baptist Easley Hospital Matching Savings and 401(k) Plan, the Greenville Health System 401(k) Savings Plan, and the Palmetto Health Matching Savings and 401(k) Plan.** You may withdraw amounts attributable to such contributions while you are still employed upon any of the following events:
  - You are at least age 59½ at the time of the distribution.
  - You have incurred a hardship, as described below.

Hardship distribution. To receive a distribution on account of hardship from an eligible contribution source (see above), you must demonstrate one of the following hardship events.

(1) You need the distribution to pay unpaid medical expenses for yourself, your spouse or any dependent.

(2) You need the distribution to pay for the purchase of your principal residence. You must use the hardship distribution for the *purchase* of your principal residence. You may not receive a hardship distribution solely to make mortgage payments.

(3) You need the distribution to pay tuition and related educational fees (including room and board) for the post-secondary education of yourself, your spouse, your children, or other dependent. You may take a hardship distribution to cover up to 12 months of tuition and related fees.

(4) You need the distribution to prevent your eviction or to prevent foreclosure on your mortgage. The eviction or foreclosure must be related to your principal residence.

(5) You need the distribution to pay funeral or burial expenses for your deceased parent, spouse, child or dependent.

(6) You need the distribution to pay expenses to repair damage to your principal residence (provided the expenses would qualify for a casualty loss deduction on your tax return, without regard to 10% adjusted gross income limit).

(7) You need the distribution to pay expenses and losses (including loss of income) incurred due to federally-declared disaster. Your principal residence or principal place of employment at the time of the disaster must be located in the federally-declared disaster area.

In addition, a hardship event described under (1), (3) or (5) above may also be determined with respect to a primary beneficiary under the Plan. For this purpose, a primary beneficiary is an individual who is named as

a beneficiary under the Plan and has an unconditional right to all or a portion of a participant's benefit upon the death of the participant.

Before you may receive a hardship distribution, you must represent, in writing, that you have insufficient cash or other liquid assets to satisfy your financial need and you must provide the Plan Administrator with sufficient documentation to demonstrate the existence of one of the above hardship events. The Plan Administrator will provide you with information regarding the documentation it deems necessary to sufficiently document the existence of a proper hardship event.

In addition, if you have other distributions available under this Plan (or any other plan we may maintain), other than Plan loans, you must take such distributions *before* requesting a hardship distribution.

You may not receive a hardship distribution of more than you need to satisfy your hardship. In calculating your maximum hardship distribution, you may include any amounts necessary to pay federal, state or local income taxes or penalties reasonably anticipated to result from the distribution. See the Plan Administrator for more information regarding the maximum amount you may take from the Plan as a hardship distribution and the total amount you have available for a hardship distribution. The Plan Administrator will provide you with the appropriate forms for requesting a hardship distribution.

Required distributions. If you have not begun taking distributions before you attain your Required Beginning Date, the Plan generally must commence distributions to you as of such date. For this purpose, effective as of January 1, 2020, your Required Beginning Date is April 1 following the end of the calendar year in which you attain age 72 or terminate employment, whichever is later. (For 5% owners, the Required Beginning Date is April 1 following the calendar year in which you attain age 72, even if you are still employed.)**

Once you attain your Required Beginning Date, the Plan Administrator will commence distributions to you as required under the Plan. The Plan Administrator will inform you of the amount you are required to receive once you attain your Required Beginning Date.

*** For Plan Years ending prior to January 1, 2020, the applicable age for determining the Required Beginning Date was 70½ (rather than age 72). Therefore, if you attained age 70 ½ prior to January 1, 2020, your Required Beginning Date is determined using age 70½.*

Distribution upon disability. If you should terminate employment because you are disabled, you will be eligible to receive a distribution of your vested account balance under the Plan's normal distribution rules. The following definition of disability applies for purposes of applying the distribution provisions under the Plan: Disability means a Participant can no longer continue in the service of his 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 his Employer.

Distributions upon death. If you should die before taking a distribution of your entire vested account balance, your remaining benefit will be distributed to your beneficiary or beneficiaries, as designated on the appropriate designated beneficiary election form. You may request a designated beneficiary election form from the Plan Administrator.

If you are married, your spouse generally is treated as your beneficiary, unless you and your spouse properly designate an alternative beneficiary to receive your benefits under the Plan. The Plan Administrator will provide you with information concerning the availability of death benefits under the Plan and your rights (and your spouse's rights) to designate an alternative beneficiary for such death benefits. For purposes of determining your beneficiary to receive death distributions under the Plan, any designation of your spouse as beneficiary is automatically revoked upon a formal divorce decree unless you re-execute a new beneficiary designation form or enter into a valid Qualified Domestic Relations Order (QDRO).

Default beneficiaries. If you do not designate a beneficiary to receive your benefits upon death, your benefits will be distributed first to the default beneficiaries identified under the Plan. Generally, distribution will be made first to your spouse and, if you have no spouse at the time of death, then equally to your children and then to your estate. However, the following special rules apply in determining the default beneficiaries under the Plan: Participant's surviving spouse, Participant's children per stirpes, Participant's surviving parents, and the Participant's Estate.

Taxation of distributions. Generally, you must include any Plan distribution in your taxable income in the year you receive the distribution. More detailed information on tax treatment of Plan distributions is contained in the "Special Tax Notice" which you may obtain from the Plan Administrator.

Distributions before age 59½. If you receive a distribution before age 59½, you generally will be subject to a 10% penalty tax in addition to regular income taxation on the amount of the distribution that is subject to taxation. You may avoid the 10% penalty tax by rolling your distribution into another plan or IRA. Certain exceptions to the penalty tax may apply. For more information, please review the "Special Tax Notice," which may be obtained from the Plan Administrator.

Rollovers and withholding. You may "rollover" most Plan distributions to an IRA or another qualified plan and avoid current taxation. You may accomplish a rollover either directly or indirectly. In a direct rollover, you instruct the Plan Administrator that you wish to have your distribution deposited directly into another plan or an IRA. In an indirect rollover, the Plan Administrator actually makes the distribution to you and you may rollover that distribution to an IRA or another qualified plan within 60 days after you receive the Plan distribution.

If you are eligible to directly rollover a distribution but choose not to, the Plan Administrator must withhold 20% of the taxable distribution for federal income tax withholding purposes. The Plan Administrator will provide you with the appropriate forms for choosing a direct rollover. For more information, see the "Special Tax Notice," which may be obtained from the Plan Administrator.

Certain benefit payments are not eligible for rollover and therefore will not be subject to 20% mandatory withholding. The types of benefit payments that are not "eligible rollover distributions" include:

- annuities paid over your lifetime,
- installments payments for a period of at least ten (10) years,
- minimum required distributions at age 70½
- hardship withdrawals, and
- Certain "corrective" distributions.

[***Note:*** *All of the above distribution options may not be available under this Plan.*]

Non-assignment of benefits and Qualified Domestic Relations Orders (QDROs) Your benefits cannot be sold, used as collateral for a loan, given away, or otherwise transferred, garnished, or attached by creditors, except as provided by law. However, if required by applicable state domestic relations law, certain court orders could require that part of your benefit be paid to someone else—your spouse or children, for example. This type of court order is known as a Qualified Domestic Relations Order (QDRO). As soon as you become aware of any court proceedings that might affect your Plan benefits, please contact the Plan Administrator. You may request a copy of the procedures concerning QDROs, including those procedures governing the qualification of a domestic relations order, without charge, from the Plan Administrator.

ARTICLE 9
PLAN ADMINISTRATION AND INVESTMENTS

Investment of Plan assets. You have the right to direct the investment of Plan assets held under the Plan on your behalf. The Plan Administrator will provide you with information on the amounts available for direction, the investment choices available to you, the frequency with which you can change your investment

choices and other investment information. Periodically, you will receive a benefit statement that provides information on your account balance and your investment returns. If you have any questions about the investment of your Plan accounts, please contact the Plan Administrator or other Plan representative.

This Plan is designed to comply with the requirements of ERISA §404(c). As such, to the extent you are permitted to direct the investment of your account, you are solely responsible for the investment decisions you make with respect to your Plan benefits. No other fiduciary, including the Trustee, Employer or Plan Administrator, will be responsible for any losses resulting from your direction of investments under the Plan. If you have questions regarding investment decisions or strategies with respect to the investment of your Plan benefits, you should consult an investment advisor.

Information Regarding Participant Investment Direction. The Plan Administrator of the Plan is responsible for providing you with certain information relating to the Plan's procedures for investment direction.

When you initially invest in an investment alternative subject to the Securities Act of 1933, you may receive a copy of the most recent prospectus for that investment alternative. However, if you received a copy of the prospectus from the Plan Administrator immediately before you invested in that investment alternative, the Plan Administrator is not required to give you a second copy.

At this time, the Plan Administrator has not designated any independent investment manager to oversee the selection and performance of investment alternatives. The Plan Administrator is responsible for those duties.

Additional information is available from the Plan Administrator. To receive this information, you must deliver a written request to the Plan Administrator. (Please contact the Plan Administrator to receive the appropriate form). Available information includes:

(a) Copies of prospectuses (or, alternatively, any short-form or summary prospectus, the form of which has been approved by the Securities and Exchange Commission) for the disclosure of information to investors by entities registered under either the Securities Act of 1933 or the Investment Company Act of 1940, or similar documents relating to designated investment alternatives that are provided by entities that are not registered under either of these Acts;

(b) Copies of any financial statements or reports, such as statements of additional information and shareholder reports, and of any other similar materials relating to the plan's designated investment alternatives, to the extent such materials are provided to the plan;

(c) A statement of the value of a share or unit of each designated investment alternative as well as the date of the valuation; and

(d) A list of the assets comprising the portfolio of each designated investment alternative which constitute plan assets within the meaning of 29 CFR 2510.3-101 and the value of each such asset (or the proportion of the investment which it comprises).

Please address any questions you have regarding your investment alternatives to the Plan Administrator or its designated representative.

Valuation Date. To determine your share of any gains or losses incurred as a result of the investment of Plan assets, the Plan is valued on a regular basis. For this purpose, the following Valuation Dates apply with respect to the various contribution types under the Plan.

- **Matching Contributions.** Your Matching Contribution Account will be valued on a daily basis. Thus, your Matching Contribution Account will receive an allocation of gains or losses under the Plan at the end of each business day during which the New York Stock Exchange is open.
- **Employer Contributions.** Your Employer Contribution Account will be valued on a daily basis. Thus, your Employer Contribution Account will receive an allocation of gains or losses under the Plan at the end of each business day during which the New York Stock Exchange is open.

Plan fees. There may be fees or expenses related to the administration of the Plan or associated with the investment of Plan assets that will affect the amount of your Plan benefits. Any fees related to the administration of the Plan or associated with the investment of Plan assets may be paid by the Plan or by the Employer. If the Employer does not pay Plan-related expenses, such fees or expenses will generally be allocated to the accounts of Participants either proportionally based on the value of account balances or as an equal dollar amount based on the number of participants in the Plan. If you direct the investment of your benefits under the Plan, you will be responsible for any investment-related fees incurred as a result of your investment decisions. Prior to making any investment, you should obtain and read all available information concerning that particular investment, including financial statements, prospectuses, and other available information.

In addition to general administration and investment fees that are charged to the Plan, you may be assessed fees directly associated with the administration of your account. For example, if you terminate employment, your account may be charged directly for the pro rata share of the Plan's administration expenses, regardless of whether the Employer pays some of these expenses for current Employees. Other fees that may be charged directly against your account include:

- Fees related to the processing of distributions upon termination of employment.
- Fees related to the processing of in-service distributions (including hardship distributions).
- Fees related to the processing of required minimum distributions at age 70½ (or termination of employment, if later).
- Participant loan origination fees and annual maintenance fees.
- Charges related to processing of a Qualified Domestic Relation Order (QDRO) where a court requires that a portion of your benefits is payable to your ex-spouse or children as a result of a divorce decree.

If you are permitted to direct the investment of your benefits under the Plan, each year you will receive a separate notice describing the fees that may be charged under the Plan. In addition, you will also receive a separate notice describing any actual fees charged against your account. Please contact the Plan Administrator if you have any questions regarding the fees that may be charged against your account under the Plan.

ARTICLE 10
PARTICIPANT LOANS

The Plan does not permit Participants to take loans from the Plan. Any outstanding loans transferred to this Plan from the Palmetto Health Matching Savings and 401(k) Plan will remain subject to the terms of those loans and the procedures developed by the Plan Administrator for administering such loans. For more information regarding the Participant loan procedures, please contact the Plan Administrator.

ARTICLE 11
PLAN AMENDMENTS AND TERMINATION

Plan amendments. We have the authority to amend this Plan at any time. Any amendment, including the restatement of an existing Plan, may not decrease your vested benefit under the Plan, except to the extent permitted under the Internal Revenue Code, and may not reduce or eliminate any "protected benefits" (except as provided under the Internal Revenue Code or any regulation issued thereunder) determined immediately prior to the adoption or effective date of the amendment (whichever is later). However, we may amend the Plan to increase, decrease or eliminate benefits on a prospective basis.

Plan termination. Although we expect to maintain this Plan indefinitely, we have the ability to terminate the Plan at any time. For this purpose, termination includes a complete discontinuance of contributions under the

Plan or a partial termination. If the Plan is terminated, all amounts credited to your account shall become 100% vested, regardless of the Plan's current vesting schedule. In the event of the termination of the Plan, you are entitled to a distribution of your entire vested benefit. Such distribution shall be made directly to you or, at your direction, may be transferred directly to another qualified retirement plan or IRA. If you do not consent to a distribution of your benefit upon termination of the Plan, the Plan Administrator will transfer your vested benefit directly to an IRA that we will establish for your benefit. Except as permitted by Internal Revenue Service regulations, the termination of the Plan shall not result in any reduction of protected benefits.

A partial termination may occur if either a Plan amendment or severance from service excludes a group of employees who were previously covered by this Plan. Whether a partial termination has occurred will depend on the facts and circumstances of each case. If a partial termination occurs, only those Participants who cease participation due to the partial termination will become 100% vested. The Plan Administrator will advise you if a partial termination occurs and how such partial termination affects you as a Participant.

ARTICLE 12
PLAN PARTICIPANT RIGHTS AND CLAIM PROCEDURES

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

- Examine, without charge, at the Plan Administrator's office, all Plan documents including copies of all documents filed by the Plan Administrator with the U.S. Department of Labor.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may assess a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive benefits under the Plan and, if so, what your current benefits are. You must request this statement in writing and you may only request this statement once a year. The Plan Administrator will provide the statement free of charge.
- File a claim for benefits.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries," have a duty to operate the Plan prudently and in the best interests of you, other Plan participants and beneficiaries. You may not be fired or otherwise discriminated against in any way solely to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforcement of Rights. If you have a claim for benefits under the Plan that 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. For example, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive the requested documents 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 documents and pay you up to $110 a day until you receive the documents, unless the documents 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 divorce decree that affects the payment of benefits under the Plan, you may file suit in federal court. If 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, if it finds your claim is frivolous.

Assistance with Questions. If you have any questions about the Plan or this SPD, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, 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 at 1-866-444-EBSA or by going online at www.dol.gov/ebsa.

Claim for Benefits. Benefits will normally be payable under the Plan without the need for a formal claim. However, if you feel you are entitled to benefits under the Plan that have not been paid, you may submit to the Plan Administrator a written claim for benefits. Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. The Plan Administrator will evaluate your claim (including all relevant documents and records you submit to support your claim) to determine if benefits are payable to you under the terms of the Plan. The Plan Administrator may solicit additional information from you if necessary to evaluate the claim.

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.

If the Plan Administrator denies all or any portion of your claim, you (and your authorized representative, if applicable) will receive within a reasonable period of time (not to exceed 90 days after receipt of the claim form), a written or electronic notice setting forth the reasons for the denial (including references to the specific provisions of the Plan on which the decision is based), a description of any additional information needed to perfect your claim, and the steps you must take to submit the claim for review. If the Plan Administrator determines that special circumstances require an extension of time for processing your claim, it may extend the 90-day period described in the prior sentence to 180 days, provided the Plan Administrator provides you with written notice of the extension and prior to the expiration of the original 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render its decision.

If the Plan Administrator denies your claim, you will have 60 days from the date you receive notice of the denial of your claim to appeal the adverse decision of the Plan Administrator. You may submit to the Plan Administrator written comments, documents, records and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. The Plan Administrator's review of the claim and of its denial of the claim shall take into account all comments, documents, records and other information relating to the claim, without regard to whether these materials were submitted or considered by the Plan Administrator in its initial decision on the claim.

If the Plan Administrator denies your claim for benefits after appeal, you will receive within a reasonable period of time (not to exceed 60 days after receipt of the appeal), a written or electronic notice setting forth the reasons for the denial (including references to the specific provisions of the Plan on which the decision is based), and a description of your right to bring an action under ERISA Section 502(a). If the Plan Administrator determines that special circumstances require an extension of time for processing your appeal, it may extend the 60-day period described in the prior sentence to 120 days, provided the Plan Administrator provides you with written notice of the extension and prior to the expiration of the original 60-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render its decision. If the Plan Administrator denies your claim for benefits upon review, in whole or in part, you may file suit in a state or Federal court.

If the Plan Administrator makes a final written determination denying your claim for benefits, you may commence legal or equitable action with respect to the denied claim upon completion of the claims procedures outlined under the Plan. Any legal or equitable action must be commenced no later than the earlier of 180 days following the date of the final determination or three years following the proof of loss. If

you fail to commence legal or equitable action with respect to a denied claim within the above timeframe, you will be deemed to have accepted the Plan Administrator's final decision with respect to the claim for benefits.

Disability Claims Procedures. If your claim is based on disability benefits, different claim procedures and deadlines will apply. If your disability benefits are provided or administered by a third party (such as Social Security Administration or an insurance company), that will be the entity to which claims are addressed.

The following disability claims procedures apply only to the determination under the Plan as to whether a Participant is entitled to a Plan benefit due to disability. These disability claims procedures do not apply if a third party (such as the Social Security Administration), rather than the Plan Administrator, makes the determination of disability. These disability claims procedures are intended to comply with the requirements of Department of Labor Regulation §2560.503-1 and will be interpreted accordingly.

These disability claims procedures are intended to ensure that disability claims procedures are reasonable, that "claimants" (which include Participants and Beneficiaries (and their authorized representatives, if applicable)) receive sufficient information explaining why disability benefits are denied and that the process is impartial.

If you have questions about the Plan's claims procedures, contact the Plan Administrator named under Article 2 of this Summary Plan Description.

Review of Initial Claim. In the case of a claim for disability benefits, the Plan Administrator will notify the claimant of an 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 Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, 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 Plan Administrator 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 Plan Administrator notifies the claimant, 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 extension, the notice of extension shall 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. The claimant shall have at least 45 days within which to provide the specified information.

Notice of Adverse Benefit Determination. The Plan Administrator will provide a claimant with written or electronic notification (written in a culturally and linguistically appropriate and understandable manner) of any "adverse benefit determination." An adverse benefit determination includes a rescission of coverage (except for non-payment of premiums). The notice of adverse benefit determination will set forth:

- 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 the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA §502(a) following an adverse benefit determination on review; and
- 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 the claimant and vocational professionals who evaluated the claimant;

  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

- 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 the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Plan Administrator will assist in language translation of a notice of adverse benefit determination, if necessary. Translation assistance can include recommending translation services, providing verbal assistance and providing the notice in a non-English language upon request.

Appeals of Adverse Benefit Determinations. A claimant shall have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Any appeal will receive a full and fair review of the claim and the adverse benefit determination. With respect to such review:

- Claimants will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Claimants (upon request and free of charge) will have reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
- The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- As soon as possible and sufficiently in advance of the date on which any notice of an “adverse benefit determination on review,” the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the person making the benefit determination in connection with the claim; and
- As soon as possible and sufficiently in advance of the “notice of adverse benefit determination on review,” the Plan Administrator will provide the claimant, free of charge, with the rationale for the adverse decision.

In performing the review, the Plan will not afford 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 initial adverse benefit determination, nor the subordinate of such individual. If the appeal is based in whole or in part 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 appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be an individual (or a subordinate of such individual) who was consulted in connection with the initial adverse benefit determination.

If the Plan obtained advice from medical or vocational experts in connection with a claimant’s adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), such experts will be identified.

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day 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.

Notice of Adverse Benefit Determination on Review. The Plan Administrator will provide a claimant with written or electronic notification (written in a culturally and linguistically appropriate and understandable manner) of any "adverse benefit determination." The notice of adverse benefit determination on review will set forth:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- That the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A description of any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures;
- A description of the claimant's right to bring an action under ERISA §502(a) (including a description of any applicable contractual limitation period that applies to the claimant's right to bring such an action);
- 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 the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or, alternatively, a statement that such explanation will be provided free of charge upon request; and
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

The Plan Administrator will assist in language translation of a notice of adverse benefit determination on review, if necessary. Translation assistance can include recommending translation services, providing verbal assistance and providing the notice in a non-English language upon request.