SECTION 125 PLAN SUMMARY PLAN DESCRIPTION
PLAN INFORMATION SUMMARY

The Employer named below establishes a Section 125 Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

SECTION 125 PLAN EMPLOYER INFORMATION

1) Name and Address of Employer: **Heritage Ministries**
4600 Route 60
Gerry NY 14740

Plan Administrator: **Heritage Ministries**

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

1. Employer's Telephone Number: **(716) 487-6800**
2. Employer's Federal Tax Identification Number: **26-1454957**
3. Additional Entities Covered:

Heritage Village Rehab & Skilled Nursing	26-1231097
Ives Hill Retirement Community Inc	16-1529379
Heritage Ministries Management Company	26-1590078
Rolling Fields, Inc.	25-1364240
The Gerry Homes Inc.	16-0755780
WNY Mennonite Retirement Community (Vinecroft)	16-1560655

4. Effective Date of this Plan: **January 1, 2025**
5. Plan Year Start Date: **January 1, 2025**
6. Last Day of the Plan Year: **December 31**
7. Subsequent Plan Years: **January 1**
8. Name of FSA Claim Administrator: **P&A Group**
6400 Main Street, Suite 210
Williamsville NY 14221
9. Name and Address of registered agent for service of legal process: **Heritage Ministries**
4600 Route 60
Gerry NY 14740

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan, except the following, provided the Employee completes a Salary Redirection Agreement ("SRA"):
Part Time and Seasonal Employees, Seasonal Workers and Interns

An eligible Employee may become a Participant in the Plan:
1st of the month following 30 days of employment

However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Medical Expense Reimbursement Plan(s) (if elected below):
1st of the month following 30 days of employment

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Non-elective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

Medical Coverage

Vision Care Coverage

Dental Coverage

Medical Care FSA Expense Reimbursement described in Appendix A to this SPD, not to exceed the maximum amount permitted under the tax code.

Dependent Care FSA Expense Reimbursement described in Appendix A to this SPD, not to exceed the maximum amount permitted under the tax code.

FSA Rollover options (IRS Notice 2013 -71 - provide for the carryover to the immediately following plan year of the IRS limit per employee of any amount remaining unused as of the end of the plan year in a Health Flexible Spending Account.

Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer, which will comply with the requirements of Article VII of the Plan

ADMINISTRATIVE EXPENSES

The Employer, except as otherwise noted in the Plan

Introduction

Heritage Ministries (the "Employer") is pleased to sponsor an employee benefit program known as a "Section 125 Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them, instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Flexible Spending Account/Dependent Care FSA. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix A to this SPD.

Questions & Answers about the Section 125 Plan

What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions".

What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with the rules outlined below; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will automatically cease, and you will not be able to make any more Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

How do I become a Participant?

You become a Participant automatically, when you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. If you do not wish to participate in the Plan, you must notify the Employer on Open Enrollment. On Open Enrollment, eligible employees need to re-elect Benefit Plans each year. Existing Benefit Plans will not roll forward to the next plan year.

The medical and dependent care FSAs must be elected annually by participants during open enrollment.

What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described below. On Open Enrollment, eligible employees need to re-elect Benefit Plans each year. Except for a Change in Status, the participant will not be permitted to modify his election until the next Annual Enrollment Period.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	**Without Cafeteria Plan**
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Monthly Savings: $31.00

How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Non-elective Contributions"). The amount of Non-elective Contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Non-elective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Non-elective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material.

Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

Change in Status. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described below);
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
- a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- ***Loss of Dependent Eligibility***. For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

  Example: Employee Bill is married to Mary, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Bill elects family coverage for himself, his wife Mary, and their child. Bill and Mary subsequently divorce during the plan year; Mary loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Bill now wishes to cancel his previous election and elect no health coverage. The divorce between Bill and Mary constitutes a Change in Status. An election to cancel coverage for Mary is consistent with this Change in Status. However, an election to cancel coverage for Bill and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- ***Gain of Coverage Eligibility Under Another Employer's Plan***. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

- ***Dependent Care Reimbursement Plan Benefits*** *(if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary)*. With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

  Example: Employee Bill is married to Mary, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Bill elects to reduce his salary by $2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years

old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Bill's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- ***Group Term Life Insurance, Disability Income, or Dismemberment Benefits*** (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary). For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Bill is married to Mary, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Bill elects $10,000 of group-term life insurance. Bill and Mary subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Bill either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

Special Enrollment Rights. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Benefit Plan or Policy for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

Effective April 1, 2009, if you or your eligible Dependent (1) lose coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) lose coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) become eligible for group health plan premium assistance under Medicaid or SCHIP and you are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependent(s) because of medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, you may be eligible to elect medical coverage under a Benefit Plan or Policy for yourself and your Dependent(s). You must request an election change to enroll in group plan coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan or (2) the Employee or dependent child is determined eligible for state premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

- **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.
- **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.
- **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan significantly increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical Care Reimbursement Plan, to the extent offered under the Plan.)

  Example: Employee Bill is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.
- **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in

Coverage" exceptions are applicable to the Medical Care Reimbursement Plan, to the extent offered under the Plan.)

- **Reduction in Hours** You are permitted to revoke an election of coverage under a group health plan due to reduction in hours of service. In order to revoke an election of coverage under a group health plan due to reduction in hours of service, you must have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change. This election may be made even if the drop in hours does not cause the employee to lose health care coverage eligibility.
- **Marketplace Open Enrollment** You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

How long will the Plan remain in effect?

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

What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the procedures explained above.

What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

What happens if I take a leave of absence?

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to

fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

- If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
- The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.
- If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules noted in this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.

How does an FSA rollover work?

This will enable employers to permit employees to use up to the IRS limit of unused health FSA amounts in the next Plan Year, instead of forfeiting the unused amounts. Individuals can now participate in a health FSA that contains this option without the risk of losing all of their unused contributions. This may also cut back on wasteful year-end FSA healthcare spending by limiting the risk of forfeiture, and in turn, reducing the incentive to spend down as year-end approaches in order to avoid losing unused funds.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Company is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs 20 or fewer employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare

- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."
If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice of your right to elect COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines
A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage
The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health Flexible Spending Account until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Company no longer provides a Health FSA to any of its employees.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 45 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

YOUR RIGHTS UNDER ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA 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 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 if you have exhausted the Plan's claims procedures. 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 if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

MISCELLANEOUS

FMLA
If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements
Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements
If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries
If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders
In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

APPENDIX A

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Company-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Additionally, if you elect to participate in the Health Savings Account you are not eligible to participate in the General Purpose Health FSA Benefit.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA is the maximum amount permitted under the tax code.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA. Medicines or drugs are eligible expenses only if the medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded).

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

If you are a participant in an Company-sponsored benefit plan, eligible expenses that are not covered under the benefit plan, such as co-payments, co-insurance or deductibles, will be automatically paid through your General Purpose Health FSA.

Contact Plan Administrator for details regarding submission of claims for reimbursement from your General Purpose Health FSA after the end of the Plan Year.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 45 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Qualified Reservist Distributions

If you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may elect to receive a distribution from your Health FSA up to an amount equal to the entire amount you elected for the applicable FSA for the Plan Year, minus reimbursements paid as of the date of the distribution request. You must make the distribution request during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

Dependent Care Flexible Spending Account

A Dependent Care Flexible Spending Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCFSA in accordance with the "Election Procedures" described above.

DCFSA Contributions
Your DCFSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCFSA is the maximum amount permitted under the tax code.

The Company will not make additional contributions to your DCFSA on your behalf.

DCFSA Eligible Expenses/Reimbursement
The entire annual amount you elect to contribute for the Plan Year to your DCFSA, less any reimbursements already distributed from your DCFSA will be available for reimbursement. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCFSA. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

Contact Plan Administrator for details regarding submission of claims for reimbursement from your General Purpose Health FSA after the end of the Plan Year.

Termination of Employment
If you terminate employment with the Company for any reason during the Plan Year, your contributions to your DCFSA will end as of your date of termination. You may submit claims for reimbursement from your DCFSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCFSA no later than 45 days after the date your employment terminates. Any balance remaining in your DCFSA will be forfeited after claims submitted prior to this date have been processed.