THE CHILDREN'S MERCY HOSPITAL
457(B) DEFERRED COMPENSATION PLAN

SUMMARY OF 457 PLAN PROVISIONS

January 1, 2022

TABLE OF CONTENTS

ARTICLE VIII
GENERAL INFORMATION ABOUT THE PLAN

THE CHILDREN'S MERCY HOSPITAL
457(B) DEFERRED COMPENSATION PLAN

SUMMARY OF 457 PLAN PROVISIONS

INTRODUCTION TO YOUR PLAN

The Children's Mercy Hospital 457(b) Deferred Compensation Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis and to provide additional income for retirement. This Plan is a type of retirement plan commonly referred to as a Tax-Exempt Organization Eligible 457 Plan. This summary of 457 Plan Provisions contains valuable information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this Summary to get a better understanding of your rights and obligations under the Plan.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this summary does not answer all of your questions, please contact the Administrator. The name and address of the Administrator can be found in the Article of this summary entitled "General Information About The Plan."

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

This summary describes the current provisions of the Plan. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS). The Employer may also amend or terminate this Plan. The Administrator will notify you if the provisions of the Plan that are described in this summary change. This summary does not address the provisions of specific investment products. This plan is not funded, which means that contributions under this Plan continue to be Employer assets and are subject to the general creditors of the Employer.

ARTICLE I
PARTICIPATION IN THE PLAN

Am I eligible to participate in the Plan?

If you are part of a select group of management or highly compensated employees described as As selected by the Employer in its discretion to be eligible to participate in the Plan. No later than November 30 of each year, the Employer will determine the eligible group of Employees for the Plan Year beginning on the next succeeding Jan. 1st, you are eligible once you satisfy the eligibility conditions, if any, described in the next question.

Independent contractors are not eligible to participate in the Plan.

When am I eligible to participate in the Plan?

Provided you are an eligible employee, you will enter the Plan once you reach the entry date as described in the next question.

When is my entry date?

The following applies with regard to entry dates: Immediately upon meeting eligibility conditions, if any.

ARTICLE II
CONTRIBUTIONS

What kind of contributions may I make to the Plan and how do my contributions affect my taxes?

As a participant in the Plan, you may elect to reduce your compensation and have that amount contributed to the Plan on a pre-tax basis. The Plan refers to this as a "salary reduction contribution". Your taxable income is reduced by your salary reduction contribution so you pay less federal income taxes. However, your salary reduction contributions are subject to Social Security taxes at the time of deferral. Later, when the Plan distributes the deferrals and earnings, you will pay income tax on those amounts. Federal income taxes on the salary reduction contributions and earnings are only postponed.

Is there a limit on the amount of salary reduction contributions that can be made each year?

As a participant, you may elect to defer a percentage of your compensation each year instead of receiving that amount in cash. The Administrator will notify you of the maximum percentage you may defer.

You may make salary reduction contributions from your accumulated leave cashouts.

Your total salary reduction contributions, plus any employer contributions, in any calendar year may not exceed a certain dollar limit which is set by law ("deferral limit"). The deferral limit for 2022 is $20,500. After 2022, the deferral limit may increase for cost-of-living adjustments.

The deferral limit described above is increased in the three years prior to your normal retirement age. This increased limit (called "Special NRA Catch-Up Contributions") is designed to allow make-up contributions for prior years when contributions to the plan were less than the maximum contribution that could have been made in those years. The additional catch-up amount is equal to the difference between the amounts that could have been contributed in the prior years less the amounts that actually were contributed in those years. However, the additional catch-up for the year cannot exceed the general limit for the year. Thus, if you are entitled to the full Special NRA Catch-up Contribution, your contributions in the last three years prior to your normal retirement age cannot exceed two times the regular deferral limit for the year.

How do I make an election to defer?

The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Plan Administrator. If you wish to defer, the procedure will require that you enter into a salary reduction agreement. You may elect to defer a portion of your compensation payable on or after your Entry Date. Such election must be made prior to the first day of a calendar month in which you wish to defer and will become effective as soon as administratively feasible after it is received by the Plan Administrator. Your election will remain in effect until you modify or terminate it. You may revoke or make modifications to your salary reduction election in accordance with procedures that the Employer provides. See the Plan Administrator for further information.

What will the Employer contribute to the Plan?

Each year, in addition to depositing your salary reduction contributions, the Employer may contribute matching and nonelective contributions.

What is the Employer matching contribution?

A matching contribution is a contribution the Employer makes based on your salary reduction contributions. If you do not make any salary reduction contributions, you will not receive any matching contributions.

The following applies to matching contributions: On a discretionary basis as determined by the Employer.

The Employer will determine its Matching Contribution based on salary reduction contributions made during each Plan Year. In applying this matching percentage, all your salary reduction contributions will be considered.

The matching contribution also applies to your Special NRA Catch-Up Contributions.

Allocation conditions. You will always share in the matching contribution regardless of the amount of service you complete during the Plan Year.

What is the Employer nonelective contribution?

A nonelective contribution is a contribution the Employer makes to the Plan which is unrelated to whether you make any salary reduction contributions in that year.

The nonelective contribution will be: On a discretionary basis as determined by the Employer.

Allocation conditions. You will always share in the nonelective contribution regardless of the amount of service you complete during the Plan Year.

What compensation is used to determine my Plan benefits?

Definition of compensation. For the purposes of the Plan, compensation has a special meaning. Compensation is generally defined as your total compensation that is subject to income tax and paid to you by your Employer during the Plan Year. The Plan takes into account salary reduction contributions to retirement plans (including this one) cafeteria plans, or qualified transportation fringe benefit plans. The following describes the adjustments to compensation that may apply for the different types of contributions provided under the Plan:

- Compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:

  – Compensation for services performed during your regular working hours, or for services outside your regular working hours or other similar payments that would have been made to you had you continued employment.

  – Compensation paid for leave cashouts, including unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued.

  – Wage continuation payments (referred to as military differential pay).

For the Plan Year in which you first participate, for any contributions other than salary reduction contributions, we take into account your full Plan Year compensation.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Administrator for further details.

ARTICLE III
DISTRIBUTIONS

When will I be entitled to a distribution from the Plan?

Distributions under the Plan may generally not be made prior to your termination of employment (for whatever reason, including death). The rules are explained in more detail below.

If you terminate employment for any reason and at any age (including retirement), then you will be entitled to a distribution as follows: 90 days after the day you terminate employment. The default payment will be made in the form of a lump sum unless otherwise indicated. (See the question "How will my benefits be paid?" for a further explanation of how benefits are paid from the Plan.)

If the Plan Administrator approves, you (1) may elect to postpone distribution of your benefit to any fixed or determinable date including, but not beyond, your "required beginning date" described below; and (2) you may elect optional forms of payment. You must make the election no later than 30 days before the date the payment would otherwise be made. Once you have made an election, you may be permitted to make one additional election to defer (but not accelerate) payment of your benefit.

Required beginning date.

Regardless of the above, the law requires that certain minimum distributions be made from the Plan. Distributions are required to begin not later than the April 1st following the later of the end of the year in which you reach age 70 1/2 or terminate employment. You should see the Plan Administrator if you think you may be affected by these rules.

How will my benefits be paid?

You or your beneficiary may, subject to the approval of the Plan Administrator, elect to receive your distribution under one of the optional forms of payments described below:

- A single lump-sum payment.
- Fixed period payments over the following period of years: 2-30.
- Installments over your life expectancy, but only if you are required to take distributions under the law because you reached your "required beginning date" (generally the later of age 70 1/2 or the date you terminate employment).
- Lifetime Annuity (single life or joint life).
- Beneficiaries can receive benefits in the form of a lump sum or a fixed period payment of 2-30 years.

What is the Plan's normal retirement age?

You will attain your normal retirement age when you reach age 65.

May I elect to roll over my account to another plan or IRA?

No, the regulations do not permit rollovers to an IRA. Rollovers are not permitted from 457(b) Deferred Compensation Plans of tax-exempt organizations.

ARTICLE IV
DEATH BENEFITS

What happens if I die while working for the Employer?

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

Your beneficiary is the person or persons whom you designate on a form the Administrator provides for this purpose.

If no valid designation of beneficiary exists, or if the beneficiary is not alive when you die, then the death benefit will be paid to the participant's estate.

When will the death benefit be paid to my beneficiary?

Your death benefit will be paid to your beneficiary and payment will be made at such time as your beneficiary elects during the initial election period and your beneficiary may make one additional election to defer consistent with the Plan. See the Plan Administrator for further details.

You should immediately report any change in your marital status to the Administrator.

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

If you terminate employment with us and subsequently die, your beneficiary will be entitled to any remaining benefits that you were entitled to as of the date of your death.

ARTICLE V
IN-SERVICE DISTRIBUTIONS

Can I withdraw money from my account while working for the Employer?

You may receive a distribution from the Plan prior to your termination of employment if you satisfy certain conditions. These conditions are described below. However, this distribution will reduce the value of the benefits you will receive when you retire. Any in-service distribution is made at your election and will be made in accordance with the forms of distribution available under the investment product you have selected or under the Plan.

You may request a distribution of up to your entire account once you reach age 70 1/2.

ARTICLE VI
TAX TREATMENT OF DISTRIBUTIONS

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

Generally, you must include any benefits under this Plan in your taxable income when the amounts become available to you. An amount is available to you when you have a right to elect to receive a distribution (even if you do not elect to currently receive the benefit). There is an exception where you can elect to delay the receipt of the benefit. This exception is explained in the Section of this summary entitled "When will I be entitled to a distribution from the Plan?". The tax treatment may also depend on your age when you receive the distribution.

ARTICLE VII
CLAIMS PROCEDURES

Can the Plan be amended?

Yes. The Employer may amend the Plan at any time. No amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

The Employer may terminate the Plan at any time. Upon termination, no more contributions may be made to the Plan. The Administrator will notify you of any modification or termination of the Plan.

How do I submit a claim for Plan benefits?

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

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. If the Plan Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the form or forms of payment, the timing of distributions and other information relevant to the payment of the benefit.

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

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days (except as provided below for disability claims) after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

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

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

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

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

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views you presented to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

- A disability determination made by the Social Security Administration and presented by you to the Plan.

(ii) Either the internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or other criteria do not exist.

(iii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge upon request.

(iv) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

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

What is the Claims Review Procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Administrator.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NOT LATER THAN 60 DAYS (EXCEPT AS PROVIDED BELOW FOR DISABILITY CLAIMS) AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

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

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

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

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

In addition to the Claims Review Procedure above, if your claim is for disability benefits and disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then:

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

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

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

(d) If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.

(e) Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the Plan Administrator must provide you with a copy of the rationale at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow you time to respond.

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

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

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination was based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) In the case of a claim for disability benefits if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration):

(i) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.

(iii) A statement of your right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to your right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

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

(iv) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- A disability determination made by the Social Security Administration and presented by you to the Plan.

If you have a claim for benefits which is denied, then you may file suit in a state or federal court. However, in order to do so, you must file the suit not later than 180 days after the Administrator makes a final determination to deny your claim.

ARTICLE VIII
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information that you may need to know about the Plan. This information has been summarized for you in this Article.

The full name of the Plan is The Children's Mercy Hospital 457(b) Deferred Compensation Plan.

This Plan was originally effective on 1/1/2002. The amended and restated provisions of the Plan become effective on 7/1/2022.

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

The Plan will be governed by the laws of Missouri.

Employer Information

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

The Children's Mercy Hospital
2401 Gillham Road
Kansas City, Missouri 64108
816-701-4041
44-0605373

Service of legal process may be made upon the Employer at the following address:

The Children's Mercy Hospital
Attn: Office of the General Counsel
2401 Gillham Road
Kansas City, MO 64108-4698
816-701-4515

Administrator Information

The Employer is the Plan Administrator. The Plan Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation and directs the payment of your account at the appropriate time. If you have any questions about the Plan and your participation, you should contact the Administrator. The Administrator may designate other parties to perform some duties of the Administrator, and some duties are the responsibility of the investment provider(s) to the Plan.

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

SUMMARY PLAN DESCRIPTION
MATERIAL MODIFICATIONS – SECURE ACT

This is a Summary of Material Modifications regarding the The Children's Mercy Hospital 457(b) Deferred Compensation Plan ("Plan"). This is merely a summary of important changes to the Plan and information contained in the Summary Plan Description ("SPD") previously provided to you. It supplements and amends that SPD so you should retain a copy of this document with your copy of the SPD. If you have any questions, contact the Administrator. If there is any discrepancy between the terms of the Plan, as modified, and this Summary of Material Modifications, the provisions of the Plan will control.

REQUIRED MINIMUM DISTRIBUTIONS. The law requires that retirement plans distribute funds at least as rapidly as specified in the required minimum distribution (RMD) rules. The Plan has been amended to conform to recent changes in those rules. The law now requires complete distributions to some beneficiaries of deceased participants within 10 years after participant's death**.** Additionally, distributions to a participant must generally begin by April 1 of the calendar year following the year the participant turns age 72 (or, in some cases, when the participant retires, if later). Previously, the age was 70 ½. For more information, see IRS Publication 590-B.