THE SOCIETY OF THE FOUR ARTS

SUMMARY PLAN DESCRIPTION

The Society of The Four Arts
2 Four Arts Plaza
Palm Beach, FL 33480

May 1, 2018
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Section 1  Introduction

The Society of The Four Arts Welfare Plan (the “Welfare Plan”) and The Society of The Four Arts 401(k) Plan (the “401(k) Plan”) (collectively the “Plans”), which are sponsored by The Society of The Four Arts (the “Employer”), give you the flexibility to make benefit decisions that are right for you and your needs. The Plans offer a broad range of benefits choices, with options for how much coverage you need and which dependents you want to cover.

This document, along with the insurance booklets and certificates, summaries of benefits, and provider contracts, policies and descriptions, is the summary plan description (“ SPD”) for the Plans. These documents describe the Plans as in effect on May 1, 2018. If the terms of this SPD conflict with the Plans’ documents, the Plans’ documents shall govern.

To help you understand your options, the Employer encourages you to review these highlights:

*Eligibility Requirements Differ by Plan.*
The eligibility requirements for each of the Plans may differ. Detailed information with descriptions of eligibility and benefits requirements are contained in the insurance booklets and certificates, summaries of benefits, provider contracts and benefit descriptions. Copies of these documents are available, without charge, from the Finance Department, upon request.

*Annual Elections.*
Elections are made each year for medical, dental and other benefits for the coming year during annual enrollment. Your new benefit elections will be in effect from May 1 through April 30. In certain instances, you may be able to change your elections during the year.

*Customizing Your Benefits.*
You may choose from a variety of benefits that the Employer provides. For these benefits, you can elect coverage for yourself and your dependents, or you can waive coverage entirely.

*Paying for Benefits.*
The Employer contributes significantly to the 401(k) Plan, and pays a major portion of the cost of your medical and dental coverage. You may pay the remaining portion through payroll deductions. You may pay with pre-tax dollars for medical, dental, and health spending accounts. You may also contribute to the 401(k) Plan with pre-tax dollars.

*Future Benefits Changes.*
The Employer expects to continue the Plans described in this SPD indefinitely, but reserves the right to amend or terminate the Plans if the Employer believes the situation
so requires. You will be notified in writing if there is any significant amendment to the Plans or if either of the Plans are terminated.

In the event of termination of any of the Plans, employees and their eligible dependents will have no further rights to benefits, except as otherwise specifically provided in the Plans’ documents. However, no modification, alteration, amendment, suspension, or termination will be made that would diminish your vested balance in the 401(k) Plan or any accrued benefits arising from incurred but unpaid claims of the employees or their covered dependents that existed prior to the effective date of the modification, alteration, amendment, suspension, or termination.

Benefits Not an Employment Contract.
The Plans described in this SPD do not constitute an employment contract, and do not provide a guarantee of future employment.

Conflicts with Plan Documents.
If there are any differences between the information contained in this SPD and the Plans’ documents, the Plans’ documents will govern.
Eligibility.
Employees who are regularly scheduled to work 25 or more hours per week and have completed 60 consecutive calendar days of employment with the Employer (the "Waiting Period") are eligible to participate in the medical and/or dental plans. Part-time employees who are regularly scheduled to work less than 25 hours per week, seasonal and temporary or substitute employees are not eligible to participate in the medical and dental plans.

Spouses and dependent children are eligible for medical and/or dental plans coverage only if you are enrolled in such coverage. An adult child of a Participant is eligible for group medical plan coverage until age 26.

To the extent required by applicable law under the Patient Protection and Affordable Care Act ("ACA"), if the Employer is determined to employ 50 or more full-time Employees, the number of hours worked to obtain full-time status for the medical plan will be determined in accordance with certain measurement rules adopted by the Employer for all Employees (including variable hour, and seasonal employees, if such classes exist within the Employer). A temporary employee is not eligible for coverage if he is eligible for health coverage through a leasing company. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations. This eligibility information is available upon request to the Plan Administrator.

Enrolling in the Medical and Dental Plans.
When you enroll, you can not only elect medical coverage (e.g., health maintenance organization ("HMO")) and if you want dental coverage, but you can also elect the level of coverage. The medical and dental plans offer the following levels of coverage:

- Employee - You only;
- Employee + spouse - You and your spouse;
- Employee + child(ren) - You and one or more eligible dependent child(ren); or
- Employee + spouse + child(ren) - You, your spouse and one or more eligible dependent children.

You choose the type of coverage and level of coverage that is the most appropriate for you and your family. You may also elect to pay your share of the premium on a pre-tax basis or on after-tax basis.

Enrollment for New Employees.
If you are a new employee, you need to file an election form with the Finance Department during your 60-day Waiting Period.
If the Finance Department receives your election before the end of your 60-day Waiting Period, your election and coverage is effective as of the first day of the month after your 60-day Waiting Period ends.

**Example:** A regular full-time employee hired on April 15 completes the 60-day Waiting Period on June 13 and may enroll in the medical and/or dental plans as of July 1.

If you do not elect to enroll (*i.e.*, you do not file an election form with the Plan Administrator) during your 60-day Waiting Period, you will not be enrolled in the medical or dental plans.

You may not change your election during the Plan Year unless you experience a Change-in-Status Event as described below.

Copies of the forms needed to enroll in the medical and/or dental plans are available from the Finance Department.

**Annual Enrollment.**
During annual enrollment, you can:

- Elect the medical and/or dental coverage you prefer,
- Change the level of medical and/or dental coverage (*i.e.*, add or drop dependents)
- Not file an election and continue to receive benefits in accordance with your current election,
- Waive coverage for the following Plan Year, or
- Change or waive your pre-tax election.

The Finance Department will provide you with annual enrollment materials.

If you enroll in the medical and dental plans during an annual enrollment period, your election will be in effect during the following twelve-month period.

If you do not file an election during annual enrollment, then your current election remains in effect during the following twelve-month period.

**Example:** During the annual enrollment period, Joe decides to change medical options, and files an election. His election will become effective as of May 1, the beginning of the Plan Year. Nancy does not want to change her election, and does not need to file a new election during annual enrollment. Her medical coverage will continue unchanged during the following Plan Year.

You may not change your election during the Plan Year unless you experience a Change-in-Status Event as described below.
Special Enrollment Rights.
If you do not enroll yourself and your spouse and dependents in the medical or dental plans after you become eligible or during annual enrollment, you may be able to enroll under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") special enrollment rules. Generally, special enrollment is available if: (i) you initially declined coverage on behalf of yourself and/or your spouse or dependents because you had other medical or dental coverage and you (or your spouse or dependents) lose eligibility for that other coverage; or (ii) after declining coverage, you have acquired a new dependent (through marriage or the birth or adoption or placement for adoption of a child) and wish to cover that person. In the former case, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group medical and/or dental plans when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the medical and/or dental plans within 31 calendar days after: (i) you lose your alternative coverage, or (ii) the date of your marriage or the birth, adoption, or placement for adoption of your child.

See Changing Your Medical and Dental Plan Election (below) for additional information about changing your election during the Plan Year or contact the Finance Department.

Changing Your Medical and Dental Plan Election.
You may enroll in the medical and/or dental plan or modify or revoke your election during the Plan Year, but only if you experience a Change-in-Status Event that affects your medical coverage or eligibility for health coverage or your spouse’s or dependents medical coverage or eligibility for health coverage under this Welfare Plan or another plan. Any change in your election must be consistent with your Change-in-Status Event. For purposes of the Welfare Plan, a Change-in-Status Event includes a change in:

- Your legal marital status (i.e., marriage, your spouse’s death, divorce, or legal separation or annulment);
- The number of your dependents (i.e., birth, adoption, placement for adoption or dependent’s death);
- Your employment status or your spouse’s or dependent’s employment status (i.e., termination or commencement of employment, a strike or lockout, commencement or return from a leave of absence, change in employment status such as from hourly to salaried, or a change in worksite);
- Your dependent’s status as a dependent under the Welfare Plan (e.g., your dependent fails or ceases to satisfy the requirements for coverage due to age or student status);
Section 2  Medical and Dental Plans, continued

- Your residence that affects your eligibility (or your spouse or dependent has a change in residence that affects their eligibility) (e.g., you move out of the HMO plan service area during the Plan Year); or
- Your spouse’s (or dependent’s) election under his or her employer’s health plan if your change under this Welfare Plan is consistent with and on account of your spouse’s (or dependent’s) change.

These are just some examples of Change-in-Status Events that may entitle you to make a change in your election during the Plan Year. Please consult the Plan Administrator for other circumstances that may be permissible Change in Status Events.

If you change your election as a result of a Change-in-Status Event, your change must satisfy a consistency requirement. This means that your election may be amended or revoked only if it corresponds to your Change-in-Status Event. For example, in the case of divorce, you could increase coverage if you become the sole wage-earner for the family unit as a result of the divorce.

You must complete the appropriate form and submit it to the Finance Department within 31 calendar days of the Change-in-Status Event if you want to change your election (60 calendar days if the event is the birth of a child). Failure to notify the Finance Department within the 31 (or, if applicable, 60) calendar day period means you will not be able to change your election until the next annual enrollment period.

Example: Steve has medical coverage for himself, his wife and two children. During the Plan Year, Steve’s wife accepts employment with a new company and becomes eligible for their health coverage. Steve and his wife decide to enroll their family in her company’s health plan. To drop their coverage during the Plan Year, Steve must submit the appropriate completed form the Finance Department within 31 calendar days of the event. If Steve does not notify the Finance Department, he must wait until the next annual enrollment period to drop the health coverage.

If you have any questions about enrolling during the Plan Year or changing your election, please contact the Finance Department.
When Medical and Dental Coverage Begins and Ends.
Generally, if you are an eligible employee, your medical and/or dental coverage begins and ends in accordance with the following table:

<table>
<thead>
<tr>
<th>Your Coverage Begins When:</th>
<th>And Your Coverage Ends:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You elect coverage as of the first day of the month after you complete the 60-day Waiting Period;</td>
<td>• On the last day of the month in which you terminate employment;</td>
</tr>
<tr>
<td>• You elect coverage during annual enrollment for the first day of the related Plan Year; or</td>
<td>• On the last day of the month in which you no longer meet the eligibility requirements;</td>
</tr>
<tr>
<td>• You experience a Change-in-Status Event that allows you to elect coverage mid-year, and you change your coverage as a result of that event.</td>
<td>• When you no longer meet your contribution responsibilities;</td>
</tr>
<tr>
<td></td>
<td>• When you fail to return from an approved leave of absence;</td>
</tr>
<tr>
<td></td>
<td>• When you die; or</td>
</tr>
<tr>
<td></td>
<td>• If the Welfare Plan terminates.</td>
</tr>
</tbody>
</table>

When your coverage ends, you (and/or your family) may be eligible for extended coverage through COBRA or you may be eligible for coverage through the federal or state sponsored insurance marketplace.

Participation During Medical Leave.
If you take an approved leave of absence that qualifies as family and medical leave under the Employer’s Medical Leave of Absence (“MLA”) Policy, or, if applicable, the Family and Medical Leave Act of 1993 (“FMLA”), you may continue to receive medical and/or dental plan benefits for yourself and your covered dependents. Coverage will terminate at the end of the calendar month in which your MLA or FMLA leave terminates and you will be eligible for COBRA continuation coverage. To receive medical and/or dental plan coverage during MLA or FMLA leave, you must continue to pay your share of the premium. If you do not continue your medical and/or dental plan coverage during MLA or FMLA leave, your coverage will be reinstated when you return from MLA or FMLA leave. You should contact the Finance Department to make arrangements for premium payments during MLA or FMLA leave or if you need additional information about medical and dental plan benefits during MLA or FMLA leave.

Participation During Military Leave.
Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.
Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (e.g., family and medical leave).

Key Terms.
In order to understand the medical plan available under the Welfare Plan, you should be familiar with the following terms:

**Annual Deductible.** For each Plan Year, the annual deductible is the amount you need to pay for covered medical expenses before the Welfare Plan starts to pay benefits. Annual deductibles vary according to the medical option. The annual deductible is shown in the benefit summaries provided by the insurers.

**Annual Out-of-Pocket Maximum.** Annual out-of-pocket maximum is the maximum you pay for health care benefits during a Plan Year. If you satisfy both your annual deductible and your annual coinsurance payments and that amount exceeds your annual out-of-pocket maximum, the Welfare Plan will reimburse most of your remaining covered expenses during the year at 100% of the covered charges. The Welfare Plan will not pay for any noncovered expenses or copayments. The annual out-of-pocket maximum is shown in the benefit summaries provided by the insurers.

**Coinsurance.** Coinsurance is the percentage the Welfare Plan pays, after you satisfy the annual deductible. Once you pay the annual deductible for covered medical expenses, the Welfare Plan pays up to a stated percentage of most covered charges. You are responsible for the balance. The coinsurance percentage is shown in the benefit summaries provided by the insurers.

**Copayment.** Copayment for the HMO means the amount you pay when you visit your primary care physician ("PCP"), another PCP-referred in-network doctor, an in-network hospital emergency room, are admitted for an inpatient hospital stay, or fill a prescription. Usually, you are responsible for payment when services are rendered. Copayments typically do not count toward coinsurance and deductible amounts. The copayments are shown in the benefit summaries provided by the insurers.
Section 2  Medical and Dental Plans, continued

Medical Plan.
The Welfare Plan provides medical coverage as follows:

Health Maintenance Organizations
Health Maintenance Organizations ("HMOs") provide comprehensive hospital and medical care through a network of doctors, specialists, and other health care providers which means an HMO provides care at a low cost to you. Generally, when you receive coverage through an HMO:

- The HMO provides benefits itself or through a network of physicians, hospitals, and other medical providers.
- The HMO generally covers 100% of the cost for most routine and preventive health care. Coverage for other benefits may vary. Refer to your HMO booklet for specific details.
- If you obtain services out-of-network, you may have to pay the full cost of the medical services unless you are receiving emergency care outside the network area.
- You are subject to annual deductibles and out-of-pocket maximums.
- You do not need to submit any claim forms.
- Benefits are generally provided outside of the network only if you are traveling outside the HMO’s coverage area and it is an emergency. You are generally required to contact your PCP or HMO within 24 to 48 hours of receiving emergency services. Please refer to your HMO booklet for the definition of an emergency, notification requirements, and any noted exceptions.

High Deductible Health Plan
One of the HMOs is a High Deductible Health Plan ("HDHP") which has a higher deductible than a traditional plan. The monthly premium is usually lower, but you may pay more for health care costs before the HDHP starts to pay its share. The HDHP requires you to pay up to the deductible limit for eligible health services. After the annual deductible has been met, you may be required to pay a portion of the health care costs (i.e., co-payments or co-insurance). Your share of the eligible health care expenses may not exceed the annual maximum out-of-pocket limit for the year.

Example. Tony has elected family coverage under the HDHP which has an $11,500 deductible, 30% coinsurance and a $13,100 annual out-of-pocket maximum for families. Tony pays the first $11,500 of covered medical expenses (the deductible), then he pays 30% of the next $5,333 (coinsurance) which equals $1,600. Tony has met the annual out-of-pocket maximum because his deductible
Section 2  Medical and Dental Plans, continued

and coinsurance equals $13,100. Because the annual out-of-pocket maximum has been met, the HDHP will pay 100% of covered medical expenses.

For additional information about your share of eligible health care expenses, please refer to the summary of benefits coverage provided by the Plan Administrator.

If you participate in the HDHP, you may, if eligible, be able to contribute to a Health Savings Account ("HSAs") allowing you to pay for certain health care expenses (e.g., deductibles, co-payments and coinsurance) with money free from federal taxes. For additional information about HSAs, please refer to Section 3.

**COBRA.**
Under a federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), the Welfare Plan is required to offer covered employees, their covered spouses and dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Welfare Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension.

**NOTE:** Individuals, who lose group health plan coverage under the Welfare Plan, may be eligible for coverage through a federal or state-sponsored insurance marketplace.

As an employee covered under the Welfare Plan, you have the right to elect COBRA continuation coverage if you lose health (i.e., medical and/or dental) coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Welfare Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or are legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.
Section 2   Medical and Dental Plans, continued

Your dependent child may continue health coverage if he or she loses health coverage (or
premium payments or contributions for health coverage increase) under the Welfare Plan
because:

- He or she loses dependent status under the Welfare Plan;
- Your employment is terminated for reasons other than gross misconduct, or your
  hours of employment are reduced;
- You die;
- You and your spouse divorce or are legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted or placed for adoption with the covered employee during the
continuation coverage period is also entitled to elect COBRA continuation coverage. Such
child’s coverage period will be determined according to the date of the qualifying event that gave
rise to the covered employee’s COBRA coverage. You must notify the Plan Administrator
within 31 days and provide supporting documentation.

Under COBRA, you (or your spouse or dependent child, if applicable) must notify the Plan
Administrator by filing a Change of Status notice with the Plan Administrator within 60 days
after:

- You and your spouse are divorced or legally separated; or
- One of your children loses dependent status under the Welfare Plan.

You (or your spouse or dependent child, if applicable) will then be notified of the right to elect
continuation health coverage and the cost to do so. The deadline for electing continuation health
coverage is 60 days after the date the Welfare Plan ceases to cover you or your spouse or
dependent child, or 60 days from the date you, your spouse, or dependent child are notified of
your COBRA election rights, whichever is later.

If you (or your spouse or dependent children, if applicable) do not elect continuation coverage,
your health coverage will stop. If you (or your spouse or dependent children, if applicable)
choose continuation health coverage, the Welfare Plan will provide health coverage identical to
that available to similarly situated active employees, including the opportunity to choose among
options available during an open enrollment period. However, you (or your spouse or dependent
child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of
the total premium paid by you and your Employer for that level of coverage. There is a grace
period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the employee,
divorce, legal separation, Medicare entitlement, or loss of “dependent status” of a dependent
child under the Welfare Plan, then each qualified beneficiary will have the opportunity to elect 36
months of continuation coverage from the date of the qualifying event. If you (or your spouse or
dependent child, if applicable) lose health coverage under the Welfare Plan because your
enrollment was terminated or your hours of employment were reduced (and not immediately
followed by termination of employment), then the maximum continuation period will be 18
months from the date of the qualifying event. (If coverage is lost at a date later than the date of
the qualifying event and the Welfare Plan measures the maximum coverage period and notice
period from the date of health coverage loss, then the maximum continuation period will be 18
months from the date of health coverage loss.) If during those 18 months, another qualifying
event takes place that entitles your spouse (or dependent child, if applicable) to continuation
health coverage, your spouse’s continuation coverage (or dependent child’s continuation
coverage, if applicable) may be extended by another 18 months. You must make sure that the
Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60
days of the second qualifying event. In no event will your spouse’s health continuation coverage
(or your dependent child’s health continuation coverage, if applicable) extend for more than a
total of 36 months from the date of the initial event. If your covered spouse and/or dependent
child lose coverage due to your termination of employment (for reasons other than gross
misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in
Medicare, then the maximum continuation coverage period for your spouse and dependent child
shall be 36 months from the date you enrolled in Medicare.
Disability is a special issue. If the Social Security Administration determined that you (or your
spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the
continuation health coverage period, or in the case of a child born to, adopted or placed for
adoption with a covered employee during a COBRA coverage period, during the first 60 days
after a child’s birth, adoption or placement for adoption, then your continuation coverage period
as well as your spouse’s and any dependent’s continuation periods may be extended from 18
months to 29 months. The Employer may charge up to 150% of the total premium paid by you
and the Employer during this extended period. To qualify, you (or your spouse or dependent
child, if applicable) must notify the Plan Administrator in writing within 60 days of the date of
the Social Security determination and during the initial 18 month continuation coverage period.
Your written notice must include your name, Social Security Number, and indicate you have
continuation coverage under the Welfare Plan. If there is a final determination that the qualified
beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the
determination by the qualified beneficiary, and any health coverage extended beyond the
maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the employer will entitle you to
continuation health coverage. If the qualifying event causing the loss of health coverage was the
bankruptcy of the employer under Title XI, then each covered retired employee will have the
opportunity to receive continuation health coverage until the death of the covered retired
employee. Covered spouses, surviving spouses and dependents of the covered retired employee
will have the opportunity to elect continuation health coverage for a period that will terminate 36
months following the death of the retired employee or upon the death of the qualified beneficiary,
whichever is earlier.
Section 2  Medical and Dental Plans, continued

Your right to continuation health coverage (or your spouse's or dependent child's right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

In order to protect your family's rights, you should keep the Plan Administrator/COBRA Administrator informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send the Welfare Plan or COBRA Administrator.

Qualified Medical Child Support Order.
The Plan Administrator has adopted procedures to comply with and enforce the Qualified Medical Child Support Order ("QMCSO") rules and regulations. A QMCSO is an order by a court for a group health plan to provide an employee's child (or children) with health insurance. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

- Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA;
- Promptly notify the employee and any alternate recipient of the receipt of any medical child support order, and the Welfare Plan's procedures for determining whether a medical child support order is a QMCSO; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator shall determine whether such order is a QMCSO and shall notify the employee and each alternate recipient of such determination.
Section 2  Medical and Dental Plans, continued

State Medicaid Programs.
Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a dependent’s in this Welfare Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a benefit program available under this Welfare Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such benefit program will govern unless the language fails to comply with applicable laws and regulations.

Special Rules For Maternity And Infant Coverage.
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Special Rule For Women’s Health Coverage.
The Women’s Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes: (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan’s policy, contact the Plan Administrator.

HIPAA Privacy.
A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Welfare Plan’s Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Finance Department.

Neither this Welfare Plan nor the Employer will use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the
Welfare Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Welfare Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Welfare Plan, your insurer; or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.
Section 3  Health Savings Account

A health savings account ("HSA") is an account established under Section 223 of the Internal Revenue Code. If you are a "Health Savings Account-Eligible Individual" (see below), you may elect to make contributions to an HSA on a pre-tax basis. The Employer will forward contributions to the HSA the Employer has selected. The election may be increased, decreased or revoked prospectively at any time during the Plan Year. Elections must be filed in such time and manner as the Plan Administrator may require.

**HSAs Not Sponsored or Maintained by Employer.**

An HSA is not an Employer-sponsored benefit plan. It is an individual trust or custodial account separately established and maintained by a trustee or custodian outside of the Welfare Plan. The Plan Administrator will maintain records to keep track of your HSA contributions. The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose.

Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by, and are set forth in, the HSA trust or custodial agreement provided by the applicable trustee or custodian. The Employer has no authority or control over the funds deposited in an HSA.

**Health Savings Account-Eligible Individual**

A Health Savings Account-Eligible Individual means an individual (other than an individual who can be claimed as a tax dependent or who is entitled to Medicare) who has elected compatible, qualifying High Deductible Health Plan coverage and who has not elected any "disqualifying coverage" pursuant to Section 223(c) of the Internal Revenue Code. A "High Deductible Health Plan" is a health plan that meets the statutory limits for annual deductibles and out-of-pocket expenses for individual coverage and for family coverage, as defined in Section 223(c)(2) of the Internal Revenue Code. Limits are set by the Internal Revenue Service to define a High Deductible Health Plan and may be adjusted for cost of living. For the annual deductible limit and the maximum out-of-pocket expenses that apply to you under the Welfare Plan, you should refer to the materials provided by the health insurance carrier.

If you are not enrolled in a High Deductible Health Plan (e.g., you enroll in a comprehensive major medical policy), you are not a Health Savings Account-Eligible Employee.

For additional information about eligibility to contribute to the HSA, contact the Plan Administrator.

**Disqualifying Coverage.**

Disqualifying coverage includes coverage under your spouse’s medical insurance plan, enrollment in Medicare or a general purpose health care flexible spending account offered under the Employer’s or your spouse’s cafeteria plan. Employees who are planning to enroll in Medicare should notify the Finance Department at least six months in advance.
Section 3  Health Savings Account, continued

If you have made an election to contribute to a general purpose health care flexible spending account plan for the prior the Plan Year, you cannot elect Health Savings Account contributions following the close of that Plan Year unless no credits remain in your general purpose health care flexible spending account.

Maximum Annual Contribution.
Your total annual contribution for HSA benefits must not exceed the statutory maximum amount for the calendar year in which the contribution is made. An additional catch-up contribution may be made if you are age 55 or older. Amounts may be adjusted for cost of living.

The maximum annual contribution shall be reduced by any Employer contributions (described below) made to your HSA during the Plan Year.

Employer Contribution.
The Employer, in its sole discretion, may make a contribution to your HSA in an amount to be determined by the Employer and communicated to you in a separate announcement.

If you are enrolled in the Welfare Plan for less than 12 months, the employer contribution, if any, will be pro-rated based on the number of months you are actually enrolled during the year.

Example. Steve is enrolled in the medical plan for 6 months. The Employer contribution to Steve’s HSA is 6/12 of the maximum Employer contribution for that year.

The Employer may change the timing or amount of or eliminate entirely its contribution at any time, and will notify you if it does so.

For additional information about HSAs, contact the Finance Department.

Employees Enrolled in Medicare.
Employees who attain age 65 are eligible for Medicare, the government medical insurance plan for older Americans. Employees who are covered under this Welfare Plan and enroll in Medicare are not allowed to make or receive contributions to their HSAs. Employees age 65 or older may remain in this Welfare Plan, but if they are also covered under Medicare, they will not receive any contributions to their HSAs and will not be allowed to contribute to their HSAs. Therefore, for employees who are participants in this plan and are enrolled in Medicare, the Employer will provide a monthly stipend of $167 which will be treated as taxable income. Employees must notify the Employer at least six months prior to enrolling in Medicare to avoid disallowed HSA deposits.
The Employer may change the timing or amount of or eliminating entirely the monthly stipend at any time, and will notify you if it does so.
Section 4  401(k) Plan

The 401(k) Plan is designed to accomplish at least two goals:

First, the 401(k) Plan provides a means for eligible employees to save a portion of their earnings from the Employer without paying current income taxes on those earnings; income taxation is deferred until the employee eventually receives a distribution from the 401(k) Plan. This feature of the 401(k) Plan is sometimes referred to as a "Section 401(k) Plan" after the section of the Internal Revenue Code that contains the rules governing qualified plans that have provisions allowing employees to make contributions on a pre-tax basis.

Second, the 401(k) Plan may enable eligible employees to accumulate additional retirement savings in the event the Employer makes a discretionary profit sharing contribution to the Plan.

For additional information about the 401(k) Plan, please refer to the Summary Plan Description ("SPD") booklet provided by the Plan Administrator.

Eligibility.
You are eligible to participate in the 401(k) Plan if you are an employee of the Employer. You are not eligible to participate in the 401(k) Plan if you are: an employee whose employment is governed by a collective bargaining agreement, a nonresident alien with no U.S.-source earned income, or you become an employee as a result of an asset stock acquisition, merger or similar transaction involving a change in the Employer or a trade or business (during the transition period only).

Participation.
You will become a participant in the 401(k) Plan for elective deferral contributions (including Roth elective deferrals) immediately on your date of hire. Elective deferral contributions begin as soon as administratively possible with the Plan’s Recordkeeper (see Automatic Enrollment).

You will become a participant in the 401(k) Plan for matching contributions and employer profit sharing contributions on the date you complete 11 months of eligibility service.

Eligibility service is the 11-month period, starting on an employee’s hire date or the first day of any later Plan Year.

Please note that you initially become a participant in the 401(k) for elective deferral contributions before you become eligible for matching contributions and employer profit sharing contributions. You do not become eligible for matching contributions and employer profit sharing contributions until you have completed 11 months of eligibility service.
Special rules apply if you terminate employment with the Employer and you are later reemployed by the Employer as an eligible employee. If you terminate employment with the Employer after becoming a participant in the Plan and you are later reemployed by the Employer as an eligible employee, you will reenter the Plan immediately upon your reemployment.

If you terminate employment with the Employer before meeting the eligibility requirements and you are later reemployed by the Employer, you will have to meet the eligibility requirements to become a participant in the Plan. If you terminate employment with the Employer and you incur a break in service (you are not credited with more than 500 hours of service during a Plan Year) while you are gone, you will be treated as a new employee upon your reemployment.

An hour of service is generally credited for every hour an employee actually works and for most paid non-working hours, such as vacation, holidays and sick days. However, no more than 501 hours of service will be credited for any single continuous period in which an employee is absent from work but continues to be paid.

Contributions to the 401(k) Plan.
Contributions to the Plan come from participants and may also come from the Employer. The types of contributions to the Plan are described in this section.

Participant Elective Deferrals.
You may make your elective deferral contributions to the 401(k) Plan by completing and submitting the appropriate forms to the Plan's Recordkeeper. Elective deferral contributions are contributions that you make to the 401(k) Plan instead of receiving those amounts in the form of cash compensation. These contributions may be made on a pre-tax basis, in which case your taxable compensation (and therefore the federal and state income taxes you pay) is reduced, or as "Roth elective deferrals" which are described in greater detail on page 21. Roth elective deferrals do not reduce your taxable compensation so you will pay income taxes on the amounts you contribute to the 401(k) Plan as the contributions are made. If you do not make an elective deferral, an automatic deferral of 10% will be your default contribution unless you choose to defer a different amount (see Automatic Enrollment).

You may submit an election form or enroll online upon becoming eligible to participate or at any later time. On the form, you must indicate the dollar amount or whole-number percentage of your "compensation" that you wish to contribute to the 401(k) Plan in lieu of receiving cash. Compensation generally means all of the earnings you receive from the Employer for services while you are eligible to participate in the Plan that are reportable as income in Box 1 on IRS Form W-2, plus the amount of any earnings that would be taxable but for your election to receive non-taxable benefits, such as pre-tax health insurance benefits, and elective deferral contributions to the Plan, up to $275,000 (in 2018, indexed for inflation each year).
After you have made an election with the Plan’s Recordkeeper, your compensation will be reduced by the amount you have elected to contribute to the 401(k) Plan. Elective deferral contributions begin as soon as administratively possible after an election is filed with the Plan’s Recordkeeper.

Automatic Enrollment - If you do not make any election with respect to elective deferral contributions, you will be deemed to have made an election to defer 10% of your compensation to the Plan. Your compensation will be reduced by 10% until you change your deferral percentage to another permissible dollar amount or percentage or discontinuing your elective deferral contributions. Elective deferral contributions made under automatic enrollment are made on a pre-tax basis and are not treated as Roth elective deferrals. If you are automatically enrolled in the 401(k) Plan, you may repeal the election and request a distribution of the elective deferrals deducted from your compensation. You must make this request within 90 days of the initial elective deferral deducted from your compensation.

Changing Your Election - You may change the rate of, or resume, your elective deferral contributions (including Roth elective deferrals) by making an election with Plan’s Recordkeeper, within a reasonable period as determined by the Plan Administrator. Any such election change will become effective as soon as administratively possible after an election is filed with the Plan’s Recordkeeper.

You may discontinue your elective deferral contributions (including Roth elective deferrals) by filing an election with the Plan’s Recordkeeper within a reasonable period (as determined by the Plan Administrator).

Elective deferral contributions (including Roth elective deferrals) are subject to some legal limits that may restrict the maximum amount you can contribute to the 401(k) Plan. One such limit is that your elective deferral contributions for any calendar year cannot exceed a certain amount. For 2018, the limit is $18,500, which will be increased with inflation for subsequent Plan Years. Another limit affects only highly compensated employees (generally employees whose annual earnings exceed $120,000, subject to indexing) whose benefits may have to be restricted to enable the 401(k) Plan to pass a special nondiscrimination test each Plan Year. Finally, elective deferral contributions are subject to an overall limit on the contributions that may be made for any participant for a Plan Year. The Plan Administrator will tell you if any of the above limits affect you for a particular Plan Year. If any of these limits would be exceeded, the 401(k) Plan will refund to the affected participant the amount of elective deferral contributions needed to stay within the limit.

Catch-up Contributions.
If you have reached, or will reach, age 50 during a calendar year, you may elect to make additional elective deferral contributions (including Roth elective deferrals) in excess of
the limits described above. To make these “catch-up contributions”, you must submit a completed election form to the Plan Administrator.

The amount that you contribute to the 401(k) Plan as a catch-up contribution for a calendar year cannot exceed $6,000 for 2018; this amount will be increased with inflation. Catch-up contributions are eligible for matching contributions.

**Roth Elective Deferrals.**

You may designate some or all of your elective deferral contributions as Roth elective deferrals. In contrast to regular elective deferral contributions, which are made on a pre-tax basis, Roth elective deferrals are made on an after-tax basis; as a result, Roth elective deferrals do not reduce your taxable income and federal and state income taxes will be withheld on amounts you designate as Roth elective deferrals.

In most respects, Roth elective deferrals are treated in the same way under the 401(k) Plan as regular elective deferral contributions. For example, Roth elective deferrals are subject to the same maximum contribution limitation as regular elective deferral contributions, and any matching contributions the Employer makes for a Plan Year will be allocated based on regular elective deferral contributions and Roth elective deferrals. In addition, you may make a direct rollover contribution to the 401(k) Plan from a Roth elective deferral account under another 401(k) plan. You also may withdraw amounts from your Roth elective deferral account after you reach age 59 ¼.

Both your Roth elective deferrals and the earnings on those contributions may be distributed to you tax-free, provided you have attained age 59 ¼ at the time of the distribution and the distribution does not occur earlier than the fifth year after the year in which your Roth elective deferrals began. If the requirements for a tax-free withdrawal or distribution are not met, you will be taxed on the earnings that are distributed, but not on the elective deferrals. Roth elective deferrals and their earnings may not be rolled over to a traditional IRA, but they can be rolled over to a Roth IRA or to another qualifying employer plan, enabling the earnings to continue to accrue on a tax-deferred (or tax-free) basis.

**Matching Contributions.**

The Employer, in its sole discretion, may make “matching contributions” for a Plan Year or any portion of a Plan Year to employees that qualify for a match. Any matching contributions will be allocated to your account only if you make elective deferral contributions (including Roth elective deferrals). You are entitled to receive a matching contribution even if you terminate during the Plan Year.

Currently, the Employer allocates matching contributions annually. Please note, however, that the Employer may at any time change the amount of matching contributions or eliminate them completely, and may change the manner in which matching contributions are allocated.
Employer Profit Sharing Contributions.
The Employer, in its sole discretion, may also make additional contributions for any Plan Year. These contributions will be allocated to your account (regardless of whether you have chosen to make elective deferral contributions) only if you have completed at least 500 hours of service during the Plan Year. Contributions are allocated in proportion to the compensation of each participant who is eligible to share in discretionary employer profit sharing contributions.

Rollover Contributions.
If you have received a distribution from a qualified plan of your previous employer, you may be eligible to “roll over” that distribution to the 401(k) Plan. A “rollover contribution” may be made as a “direct rollover” from your previous employer’s plan or as a transfer within 60 days after you have received the distribution from the previous employer’s plan. You may also be eligible to roll over a distribution from a 403(b) annuity, an eligible governmental plan or an individual retirement account. Direct rollovers of Roth contributions made to another plan (but not to a Roth IRA) are permitted. The Plan Administrator must approve all rollover contributions in advance. If you wish to make a rollover contribution, the Plan Administrator may require you to demonstrate that the legal requirements for a rollover contribution are satisfied. You should not withdraw funds from any other plan or account until you have received written approval from the Plan Administrator for the rollover into the 401(k) Plan.

Overall Limit on Contributions.
The limit on the total contributions (excluding catch-up contributions and rollover contributions) that may be made to the 401(k) Plan for any participant for any Plan Year is the lesser of $55,000 (in 2018, indexed for inflation thereafter) or 100% of the participant’s compensation.

Special Compliance Provision.
In an effort to keep retirement plans from favoring “key employees”, Congress has put a complicated set of rules in the Internal Revenue Code that apply to any “top-heavy” retirement plan. Stated simply, the 401(k) Plan will be “top-heavy” if the value of the accounts of key employees (generally officers and shareholders) exceeds 60% of the value of the accounts for all participants.

Each year the 401(k) Plan will be tested to determine if it is top-heavy. If the 401(k) Plan becomes top-heavy, special rules will become effective which could increase the amount of contributions the Employer makes to your account.

Plan Accounts; Allocations To Accounts.
All participant and Employer contributions to the 401(k) Plan are transferred to a trust fund, which is held by the trustee for the exclusive benefit of the participants. A separate account is
established for you, reflecting the contributions that have been made by you or on your behalf, any investment income (or loss) allocable to your account, and any distributions or withdrawals from your account.

All of your elective deferral contributions (including Roth elective defer:als) are allocated to your account within the trust fund. In addition, any discretionary employer profit sharing contributions and matching contributions made on your behalf are allocated to your account. The Plan Administrator will keep track of the elective deferral contributions (including Roth elective deferrals which are separately accounted for in order to preserve their special tax treatment when they are distributed), any discretionary employer profit sharing contributions or matching contributions, and any rollover contributions made to your account. The Plan Administrator will periodically provide you with a statement showing the amounts held in your account.

**Investment Of Contributions.**
You may direct how your 401(k) Plan account balance is invested among the 401(k) Plan’s available investment options. Information concerning the investment funds is provided to you separately.

You make your initial investment election when you enroll in the 401(k) Plan. Your accounts will remain invested in that fund until you change your investment election in the manner described below.

You may change your investment election with respect to future contributions made to your accounts and/or change how your existing account balance is invested in accordance with procedures established by the Plan Administrator. You should review these procedures carefully before you give investment directions. In addition, you can obtain other important information from the Plan Administrator on directed investments, as described below.

When you direct investments, your account is segregated for purposes of determining the gains, earnings or losses on these investments. Your account does not share in the investment performance of other participants who have directed their own investments.

In directing your investments, you should remember that the amount of your benefits under the 401(k) Plan will depend in part upon your choice of investments. If you choose investments that produce gains and other earnings your benefits will tend to increase in value over time. Conversely, if you choose investments that have losses, your benefits will tend to decrease in value over time. Losses can occur and there are no guarantees of performance. The Employer, the Plan Administrator, the trustee, and their representatives, will not provide you with investment advice, nor do they insure or otherwise guarantee the value or performance of any investment you choose.
Section 4  401(k) Plan, continued

NOTE: There may be circumstances under which limitations on fund transfers are imposed (e.g., in the event of excessive mutual fund trading). Please refer to the various fund prospectuses, as amended from time to time, for more information on any trading restrictions that may apply.

The Employer and the Plan Administrator will select a series of funds into which you may direct the investment of your account balance. You are entirely responsible for any investment selections that you make. Further, the Employer and the Plan Administrator reserve the right, in their sole discretion, to change the mix of investment selections at any time. You will be notified of any such changes.

404(c) Compliance.
The 401(k) Plan is intended to meet the requirements of Section 404(c) of the Employee Retirement Income Security Act of 1974 (“ERISA”) and the Department of Labor regulations implementing that provision. This means that the fiduciaries of the 401(k) Plan, such as the Employer, the Plan Administrator and the trustee, may be relieved of liability for any losses that are the direct and necessary result of investment instructions given by a participant.

Certain information is given to you automatically in connection with the investment of your account balance under the 401(k) Plan. In addition, the following information can be obtained upon request from the Plan Administrator’s representative:

(i) a description of the operating expenses of each of the 401(k) Plan’s specific investment options;

(ii) information concerning the value of units or shares in the 401(k) Plan’s specific investment options and their historical performance;

(iii) a listing of assets comprising the portfolio of each investment fund, the value of such assets (or the proportion of the investment fund that it comprises) and, with respect to each asset that is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term of the contract and the rate of return of the contract;

(iv) copies of prospectuses, financial statements and reports, and other materials provided to the Plan regarding its investment options; and

(v) information concerning the value of shares or units in each specific investment option in which the requesting participant has funds invested.

The name, address and telephone number of the 401(k) Plan fiduciary responsible for providing the above information is as follows and the Plan’s Recordkeeper, Paychex, Inc., will assist in this process.

The Society of the Four Arts         Paychex, Inc.
Section 4  401(k) Plan, continued

There is generally a prospectus for each of the investment funds available through the 401(k) Plan. The prospectus describes the fund’s investment objectives, strategies and risks, presents historical performance figures for the fund, and details the fund’s operating expenses. You are encouraged to read all of the prospectuses carefully so that you can choose which investment funds are best suited for you. You can get updated prospectuses and investment information for these funds by contacting the Plan’s Recordkeeper.

Each of the investment funds made available through the 401(k) Plan may have certain operating expenses, such as fund management fees, brokerage commissions, transfer taxes and other expenses. The expenses of each fund are generally deducted from the assets of the fund and are therefore reflected in each fund’s share price. As a result, each fund’s expenses are borne by the participants’ investment in that fund. Not all of the funds have the same type or amount of expenses. More specific information about the expenses incurred by each fund is contained in that fund’s prospectus, which you are encouraged to read.

Vesting In Accounts.
You are always 100% vested in your accounts in the 401(k) Plan, including your elective deferral contributions account, Roth elective deferral contributions account, employer profit sharing contributions account, matching contributions account and rollover contributions account. This means that you will always be entitled to receive 100% of the value of these accounts in the 401(k) Plan, even if you terminate employment before retirement.

Withdrawals Or Distributions From The 401(k) Plan.
Since the 401(k) Plan is regarded under the federal tax laws as a program to provide retirement benefits, withdrawals or distributions of money from the 401(k) Plan before retirement are restricted and may be subject to penalty taxes (as well as regular income taxes) in certain circumstances. You should therefore treat the 401(k) Plan as a means to accumulate tax-advantaged savings and to invest for the long term, and should not use the 401(k) Plan to make short-term investments.

Withdrawals from Accounts While Actively Employed.
While you are an active employee of the Employer, withdrawals or distributions from the 401(k) Plan can be made only after you reach age 59½, attain normal retirement age (age 65) or become disabled.
For purposes of this 401(k) Plan, disability means the inability to engage in any substantial, gainful employment by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months. The permanence and degree of an impairment must be supported by medical evidence as required by the Plan Administrator.

Distributions Following Retirement or Termination of Employment.
If you terminate employment and your account balance (including rollover contributions) does not exceed $5,000, distribution will be made in a lump sum payment as soon as practicable following your termination of employment, even if you do not request payment. If your total account balance (including rollover contributions) exceeds $5,000, you must file the appropriate form with the Administrator to request a distribution of your benefit, and the amount payable under the 401(k) Plan will be distributed as soon as administratively feasible in a single sum payment following receipt of your written request for payment.

Generally, distributions do not occur until after a participant has terminated employment with the Employer.

Form of Benefit Distribution.
The forms of distribution available under the 401(k) Plan are: a lump sum payment, partial payment or installment payment. If you have any questions regarding a distribution, please refer to the SPD booklet or contact the Plan Administrator or the Recordkeeper.

Death Benefits.
If a participant or former participant dies, the death benefit payable under the 401(k) Plan is the deceased participant’s full account balance.

If you die while you are an employee of the Employer, the death benefit payable under the 401(k) Plan is your full account balance, regardless of the years of service you have completed. In all other cases, the death benefit is your vested account balance.

In general, you are entitled to designate a beneficiary by filing a written form with the 401(k) Plan Administrator. If you are married, however, you may not designate any beneficiary other than your spouse unless your spouse consents in writing to the designated beneficiary and your spouse’s consent is witnessed by a notary public or a representative of the 401(k) Plan. More information concerning the rules for designating a beneficiary is available in the SPD booklet and from the Plan Administrator.

If your account balance does not exceed $5,000, your account will automatically be distributed to your beneficiary as soon as practicable following your death, even if your beneficiary does not request payment. Otherwise, your beneficiary must file the appropriate form with the
Administrator to request a distribution of your benefit. If your beneficiary does not request a
distribution, payment will be made no later than the end of the year following the year in which
your death occurs.

Tax Considerations.
The discussion in this subsection is intended to provide general guidance with respect to the tax
rules affecting you as a result of your participation in the 401(k) Plan. Because of the complexity
of these rules, the frequency with which they are changed and the fact that each person’s
circumstances are unique, you are urged to consult with a personal tax adviser regarding the tax
aspects of your participation in the 401(k) Plan and receipt of benefits under the 401(k) Plan.

Tax Treatment of Contributions.
In general, all of your elective deferral contributions (including catch-up contributions)
when made to your 401(k) Plan account are excluded from your income for Federal
income tax purposes, but these contributions are includable in your income for Social
Security tax purposes. Elective deferral contributions (including catch-up contributions)
when made to your 401(k) Plan account are also excludable from your income for state
income tax purposes. Roth contributions (including catch-up contributions made as Roth
contributions) are included in your income for Federal and state income tax purposes and
for Social Security tax purposes.

The Employer’s discretionary profit sharing contributions and matching contributions are
not subject to any tax when made to your 401(k) Plan account.

Rollover contributions are not subject to tax when made to your 401(k) Plan account.

Tax Treatment of Investment Accounts.
The trust that holds all 401(k) Plan investments and your 401(k) Plan account is exempt
from Federal and state income taxes. Therefore, any interest and dividends paid to, as
well as capital gains and appreciation in value realized by, the trust are not subject to
taxation as long as the assets remain in the trust.

Tax Treatment of Distributions to Participants.
A distribution of benefits from the 401(k) Plan to you or your beneficiary generally is
subject to both Federal and state income tax, but not Social Security tax. Several
exceptions and special rules may apply, however, either with regard to the taxability of
these amounts or with respect to the rate or method of computing the tax. Here are some
of the more important rules and exceptions:

Pre-Age 59½ Distribution Penalty Tax. Subject to certain exceptions,
distributions from the 401(k) Plan made before you attain age 59½ are subject to
regular income taxes plus a 10% Federal penalty tax. If all or a portion of a pre-
age 59½ distribution consists of Roth contributions made to the 401(k) Plan or
rolled over from another 401(k) plan, only the earnings on such amounts will be subject to regular income taxes, but the entire amount of the distribution will be subject to the 10% penalty tax. The exceptions to the penalty tax (but not to the income tax) include distributions on account of your death, disability or separation from service after age 55.

**Rollover of Distribution.** If the distribution you receive from the 401(k) Plan qualifies as an "eligible rollover distribution," you may be able to roll over all or part of the distribution to an individual retirement account ("IRA"), 403(b) annuity contract or the retirement plan of a new employer. The amount rolled over will not be subject to income taxes or to the 10% penalty tax. An eligible rollover distribution includes any lump sum payment, other than a hardship withdrawal.

A participant’s surviving spouse also may roll over a death benefit to an IRA, 403(b) annuity contract or the retirement plan of a new employer, but a death benefit payable to a participant’s designated beneficiary may only be rolled over to an IRA that has been established to receive the rollover. The amount rolled over will not be subject to income taxes or the 10% penalty tax.

You, your surviving spouse or your designated beneficiary may also be able to roll over all or part a lump sum payment to a Roth IRA. The amount rolled over will be subject to income taxes at the time of the rollover, but both the amount rolled over and future earnings on that amount will not be subject to income taxes or to the 10% penalty tax if they are distributed from the Roth IRA after you have attained age 59½ and if at least five years have expired since the Roth IRA was established. Otherwise (with limited exceptions), any earnings that are distributed from the Roth IRA will be taxable and potentially subject to an early withdrawal penalty.

Roth contributions, any amount you rolled over to the 401(k) Plan that consists of Roth contributions from another 401(k) plan and the associated earnings may not be rolled over to a traditional IRA, but they may be rolled over to a Roth IRA or to another qualifying employer plan that will accept such a direct rollover, which might be desirable if you wish to continue to have the earnings accrue on a tax-deferred (or tax-free) basis. Moreover, when you roll over your Roth contributions from one 401(k) plan to another 401(k) plan, the entire account under the second 401(k) plan will be treated as if you started making Roth contributions in the earliest year of the two 401(k) plans when determining whether you have satisfied the five-year requirement to avoid income taxes and potential penalties on a withdrawal or distribution of earnings.

**Tax Withholding.** Most distributions of benefits from the 401(k) Plan are subject to mandatory tax withholding, unless you elect to have a direct rollover of the
Section 4  401(k) Plan, continued

benefit amount to an IRA, 403(b) annuity contract or the retirement plan of a new employer. Before you receive a distribution, the Plan Administrator will provide a written notice explaining the rules under which you may elect to have a payment from the Plan transferred in a direct rollover as well as a description of your right to defer receipt of the distribution and the consequences of deferring or failing to defer receipt of the distribution.

Roth contributions, any amount you rolled over to the 401(k) Plan that consists of Roth contributions from another 401(k) plan and the associated earnings may be distributed to you tax-free, provided you have attained age 59½ at the time of the distribution and the distribution does not occur earlier than the fifth year after the year in which your Roth contributions first started (under the Plan or, if you rolled over Roth contributions from another 401(k) plan, under the other 401(k) plan). If the above requirements for a tax-free withdrawal or distribution are not met, you will be taxed on the portion of the payment attributable to earnings (but not contributions).

Because of the complexity of the distribution rules, you are encouraged to consult with a professional tax advisor before you receive your distribution from the 401(k) Plan.
Section 5  Administration of the Plans

General Plan Information.

Plan Sponsor: The Society of The Four Arts (the “Employer”)
2 Four Arts Plaza
Palm Beach, FL 33480

Plan Sponsor’s Employer Identification Number: 59-0454318

Plan Administrator: The Society of The Four Arts
2 Four Arts Plaza
Palm Beach, FL 33480

Agent for Service of Legal Process: The Society of The Four Arts
2 Four Arts Plaza
Palm Beach, FL 33480

Service of legal process may also be made upon the Plan Administrator. In the case of the 401(k) Plan, notice of legal action also may be served on the trustee, whose name and address appear under “Detailed Plan Information” later in this section.

Plan Administration: The 401(k) Plan is administered by a third party administrator.

The Welfare Plan is administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers who guarantee the benefits. Self-insured or unfunded benefits are paid from the Employer’s general assets.

401(k) Plan’s Recordkeeper: See chart at the end of this Section.

Claims Administrators: See the chart at the end of this Section.

Additional Plan Information: The chart at the end of this Section includes other information about your ERISA plans, including the following:
Section 5  Administration of the Plans, continued

- Plan name;
- Plan number;
- Plan Year; and
- Insurer or administrator’s name.

**Plan Administrator’s Discretion.**
With the exception of plans or programs that provide benefits through insurance contracts, the Plan Administrator has the sole and absolute discretion to construe and interpret any and all provisions of the Plans described in this SPD, to determine eligibility under the Plans, and to decide all matters of fact in granting or denying benefit claims, including, but not limited to, the discretion to conclusively resolve ambiguities, inconsistencies or omissions; provided, however, that all discretionary interpretations and decisions will be applied in a uniform and nondiscriminatory manner to all employees and their eligible dependents. The Plan Administrator may delegate to any other person or organization any of its powers, duties and responsibilities with respect to the operation and administration of the plans, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret plan provisions.

For plans that provide benefits through insurance contracts, the powers, duties and responsibilities described above generally reside with the insurer, except that the Plan Administrator continues to have the sole and absolute discretion to determine eligibility under the terms of the plans or programs.

**If Your Claim Is Denied.**
Occasionally, disagreements about benefit eligibility or amounts arise. In most cases, they can be resolved quickly and easily by contacting the Finance Department. If an issue is not resolved, you should know that there are formal procedures in place so you can appeal the decision.

The claims procedures differ according to the type of benefit. Special rules apply to benefits based on a determination of disability and to group health plans.

You should carefully review the procedures for the applicable benefit plan if you want to appeal a claim.

**General Claims Procedures.**
General claims or requests should be directed to the Claims Administrator (e.g., the insurer or the 401(k) Plan’s Recordkeeper).
Section 5  Administration of the Plans, continued

If a claim under the 401(k) Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan for which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If the Claims Administrator fails to respond within 90 days, your claim may be treated as denied. However, this period may be extended to 180 days under certain circumstances. Within 60 days after a denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator. Any request for reconsideration must include documents or records to support your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. This period may be extended to 120 days under certain circumstances. In its response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the 401(k) Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the 401(k) Plan. The Claims Administrator’s decisions are final, conclusive and binding.

The rules for the Welfare Plan are described in the applicable insurance certifications and booklets.

Other Situations Affecting Plan Benefits.
There are certain situations that may affect your right to receive a benefit under the Plans described in this SPD. Benefits could be lost or delayed for you or your covered dependent if:

- You submit improper claim information or fail to substantiate a claim for payment;
- You have a change in address and fail to notify the Finance Department;
- You fail to follow authorization or approval requirements under the medical or dental plans;
- You fail to submit claims within the timeframes allowed under the plans;
- You fail to submit valid welfare plan elections during annual enrollment;
- You (or your dependent) no longer meet a plan’s eligibility requirements;
- Your spouse becomes divorced or legally separated from you, or your marriage is annulled (for welfare plans);
- You become subject to IRS contribution maximums or to nondiscrimination rules;
- The value of your 401(k) Plan account goes down;
- A court issues a Qualified Domestic Relations Order (“QDRO”) with respect to your benefits under the 401(k) Plan;
- The Plans are modified to reduce or eliminate certain benefits (to the extent permitted by law), or a Plan is terminated;
- You fail to notify The Society of The Four Arts of your intention to retire or leave the Employer;
- Your employment status changes; or
- Your employment with The Society of The Four Arts terminates.
Section 5  Administration of the Plans, continued

This list of examples does not cover every situation in which you could lose your right to receive benefits. In all cases, the terms of the benefit plan as interpreted by the Plan Administrator and, if applicable, the insurance contract as interpreted by the insurer, govern your right to plan benefits. In the event of any discrepancy between this SPD and the actual provisions of any benefit plan, the plan document and, if applicable, the insurance contract, will govern.

Plan Amendment or Termination.
While the Plans are expected to continue indefinitely, The Society of The Four Arts reserves the right to modify or amend the Plans, in whole or in part, at any time. Each modification or amendment must be in accordance with applicable laws and regulations. Generally, any amendment or modification may not decrease the benefits you have earned under the 401(k) Plan as of the date that action was taken.

These Plans may be terminated, in whole or in part, by The Society of The Four Arts Board of Trustees, at any time, for any reason upon proper notice to you (or to your beneficiaries whose 401(k) Plan benefits are in payment status). In the event of any such termination, the rights you have earned up to the date of the termination, to the extent then funded, will be nonforfeitable.

Assignment of Benefits.
Your benefits generally cannot be alienated or assigned to another person, except in the case of a QDRO. In that event, the court can assign benefits under the 401(k) Plan to another person. The 401(k) Plan maintains procedures governing QDROs. A copy of the procedures is available from the Finance Department, without charge, upon request.

Effect on Employment.
Nothing in this SPD should be construed as a guarantee of continued employment with the Employer.

Responsibility For Goods/Services.
The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program, because these goods and services are provided by personnel and agencies outside the control of the Employer.

Your Rights Under ERISA.
As a participant in The Society of The Four Arts Plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:
Section 5  Administration of the Plans, continued

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual reports (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee and Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plans’ annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plans 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 plans for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a pension or 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 plan documents or the latest annual reports from the plans 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plans’ 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 it should happen that Plan fiduciaries misuse the Plans’ money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plans, 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.
This chart provides you with important information about the Plans described in this SPD.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Plan Name and Plan Number</th>
<th>Plan Year</th>
<th>Type of Plan</th>
<th>Claims Administrator's/Recordkeeper's Name and Address</th>
<th>Type of Administration</th>
<th>Plan Administrator*</th>
<th>Plan Trustee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>The Society of The Four Arts Welfare Plan (501)</td>
<td>May 1 – April 30</td>
<td>Medical</td>
<td>Aetna Health, Inc. 1-866-529-2517 <a href="http://www.aetna.com">www.aetna.com</a></td>
<td>Co-pay HMO Insured; Group medical insurance policies HDHP HMO; level funded plan which is partially self-insured and partially self-funded</td>
<td>The Society of The Four Arts 2 Four Arts Plaza Palm Beach, FL 33480 1-561-659-8508</td>
<td>N/A</td>
</tr>
<tr>
<td>Dental Plan</td>
<td>The Society of The Four Arts Welfare Plan (501)</td>
<td>May 1 – April 30</td>
<td>Dental</td>
<td>Principal Life Insurance Company 1-800-247-4695</td>
<td>Insured; Group dental insurance policies</td>
<td>The Society of The Four Arts 2 Four Arts Plaza Palm Beach, FL 33480 1-561-659-8508</td>
<td>N/A</td>
</tr>
<tr>
<td>401(k) Plan</td>
<td>The Society of The Four Arts 401(k) Plan (003)</td>
<td>January 1 – December 31</td>
<td>Defined Contribution</td>
<td>Paychex, Inc. 1175 John Street West Henrietta, NY 877-244-1771</td>
<td>Sponsor administration</td>
<td>The Society of The Four Arts 2 Four Arts Plaza Palm Beach, FL 33480 1-561-659-8508</td>
<td>Counsel Trust DBA MATC 1251 Waterfront Place, Suite 525 Pittsburgh, PA 15222-4228 412-391-7077</td>
</tr>
</tbody>
</table>

* The Plan Administrator may delegate its duties and responsibilities with respect to the benefits described in this chart. See “Claims Administrator’s/Recordkeeper’s” column.