Summary Plan Description

of the

SCHUPAN & SONS, INC.

FLEXIBLE BENEFIT PLAN

Effective: January 1, 2021

TO OUR EMPLOYEES

SCHUPAN & SONS, INC. ("Employer") maintains the **Schupan & Sons, Inc. Flexible Benefit Plan** ("Plan") for the benefit of its employees. The Plan allows you to design your own benefits package to suit your individual needs.

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Plan. You should read this Summary Plan Description carefully and keep it for future reference. This Summary Plan Description does not replace the provisions of the Plan document. The Plan document governs the operation of the Plan. Every effort has been made to make this Summary Plan Description as complete and accurate as possible, without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan document, the terms of the Plan document will control.

The existence of the Plan does not grant you any legal right to continue employment with Employer, or affect Employer's right to discharge you.

If you have any questions about your benefits under the Plan, please contact Employer's representative listed in the last section of this Summary Plan Description.

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WHAT IS THE FLEXIBLE BENEFIT PLAN?

The Flexible Benefit Plan is a plan which allows you to design a benefits package to suit the individual needs of you and your family. You have the following benefit choices under the Plan:

- You may elect to pay your portion of the premium for various health and welfare coverages under Employer's group insurance plan(s) on a before-tax basis.

- If provided by Employer and if you have other medical coverage (for example, through your spouse's employer), you may waive Employer-provided medical coverage and receive additional compensation.

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying health care expenses.

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying dependent care expenses.

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections are explained in the following sections of this Summary Plan Description. Although the Plan is intended to comply with the Internal Revenue Code's provisions for flexible benefit plans, Employer does not guarantee this or any other tax consequences.

References are made throughout this Summary Plan Description to the "plan year." Benefits under the Plan are elected on a plan year basis. The plan year is the 12-month accounting period for the Plan and is set forth in the last section of this Summary Plan Description. Any references to "calendar year" mean the 12-month consecutive period beginning January 1 and ending on December 31.

References are also made throughout this Summary Plan Description to your "spouse" and your "dependents." For purposes of paying premiums for health and other coverage which includes spouses and dependents, the Plan relies on the definitions of those terms in the underlying documents for that coverage. For purposes of obtaining reimbursement for qualifying expenses from your flexible spending accounts, the definition of spouse means your legally married spouse (of the same or opposite gender), based on the laws of the state or jurisdiction where the marriage occurs. For other purposes under the Plan, such as determining whether required contributions for coverage can be paid pre-tax, and the maximum contribution limits for dependent care spending accounts and health savings accounts, these terms must be defined pursuant to the Internal Revenue Code.

PARTICIPATION

Beginning of Participation

You may become a participant in the Plan on the day you become eligible to participate in Employer's group insurance plan(s).

Termination of Participation

If you terminate employment with Employer or otherwise become ineligible to participate in the Plan, your participation in the Plan will terminate on the last day you are an eligible employee. Your termination will have the following consequences:

- You will no longer be eligible to use before-tax income to pay for coverage under Employer's group insurance plan(s).
- You will no longer be eligible to receive additional compensation for waiving the Employer-provided medical coverage.
- You will no longer be eligible to set aside additional pre-tax income to pay for the reimbursement of certain health care expenses or dependent care expenses.
    - If you have an amount remaining in your health care flexible spending account when you stop participating in the Plan, you may continue to turn in claims for reimbursement of expenses incurred before you terminated participation. You are generally not eligible to be reimbursed for claims occurring after you terminated participation. If you have an amount remaining in your health care flexible spending account when you stop participating in the Plan, you may be eligible to continue participation pursuant to COBRA (see the "Other Rules Regarding Your Flexible Spending Accounts" subsection later in this Summary Plan Description).
    - If you have an amount remaining in your dependent care flexible spending account when you stop participating in the Plan, the amount in your account may continue to be applied toward the reimbursement of claims for eligible expenses incurred through the date your participation terminated.

In addition, Employer may terminate your participation in the Plan for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or a claim for benefits.

If you are rehired during the same plan year in which you terminate employment, there are special rules which may apply to you. If you become eligible to participate in the

Plan again during the same plan year, you should contact Employer for further details regarding these special eligibility rules.

BENEFIT CHOICES

For each plan year, you may choose from the following benefits:

Health and Welfare Benefits

Employer maintains one or more group insurance plans which provides you and your dependents with various health and welfare coverages. You may be required to pay a portion of the cost of certain coverages if you decide to participate. You have two choices with regard to the coverages for you and your dependents:

- You may elect to receive the coverages and pay your share of the cost with your before-tax pay reductions.

  Contributions for health coverage are made on a pre-tax basis. However, if the contributions are to obtain coverage for a dependent who is not your legally married spouse (same or opposite gender), your dependent child until the end of the year he or she attains age 26, or your qualifying child or qualifying relative, the fair market value of the health coverage for that dependent will be included in your gross income.

- You may elect to waive the coverages. However, you may only waive medical coverage for yourself and your dependents if permitted by Employer. If you elect to waive medical coverage, you may be required to certify that you have alternate medical coverage. If medical coverage is waived, Employer may pay additional compensation to you which you may elect to have credited to your flexible spending accounts or alternatively, may receive in your paychecks during the plan year for which the medical coverage was waived. (Any amounts credited to your flexible spending accounts are not taxable.)

Flexible Spending Accounts

You may use your pay reductions to obtain reimbursement of qualifying health care expenses and/or dependent care expenses (see the "Your Flexible Spending Accounts" section).

PAY REDUCTIONS

You may select different types of tax-free benefits under the Plan by reducing your pay for each pay period during the plan year to purchase the benefits. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you

will not pay income taxes on this portion of your pay. In addition, your before-tax pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need coverage under Employer's group insurance plan(s), or will incur an expense which may be reimbursed through your flexible spending accounts, you could reduce your pay and obtain the coverage or pay the reimbursable expense with "before-tax" income rather than "after-tax" income.

A disadvantage is that the before-tax pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the "CHOOSING YOUR BENEFITS" section below).

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election before the date that you become a participant in the Plan. Employer will inform you of the election procedures. The election process may require the completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make an election before the date that you become a participant in the Plan, you may not pay your required cost for any health or welfare coverages under Employer's group insurance plan(s) on a before-tax basis for the remainder of the plan year. Further, you will not receive any additional compensation for waiving medical coverage. Finally, your right to reimbursement from the flexible spending accounts will also be waived for the remainder of the plan year. Instead, you will receive your regular pay for the remainder of the plan year through Employer's payroll system.

There is an exception to these rules if you are a new employee who becomes eligible to participate in the Plan on your date of hire. In this situation, if you make your election within the next 30 days after you start working, the election will be retroactively effective to your first day of employment.

Annual Benefit Selection

For each type of benefit, there will be an open enrollment period before the start of each plan year. You may make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period for that particular benefit if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make a new election during the open enrollment period, your prior election regarding the health and welfare coverages under Employer's group insurance plan(s) will be continued. You will be considered to have agreed to pay the appropriate premium for the subsequent plan year for the coverages. However, no pay reductions will be credited to your flexible spending accounts unless you make a new election for each plan year.

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election, but in no event may you change your benefit election for a plan year after that plan year ends. The next sections describe these situations.

Change In Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;

- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, student status, or any similar circumstance; or

- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

- If you want to decrease or cancel Employer-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.

- With respect to any group term life insurance or disability benefit election, an election to increase or decrease coverage will be permitted.

- With respect to your health care spending account, you may elect to decrease your annual contribution amount, but not below the amount that has already been reimbursed to you for the plan year.

- With respect to your dependent care spending account, an election change may be made if your dependent attains age 13 or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

Changes to Coordinate with Health Care Reform

Under Health Care Reform, you may become eligible for Employer-provided group health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel Employer-provided group health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined under Health Care Reform) which is effective no later than the first day of the second month

following the month that includes the date your Employer-provided group health coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined under Health Care Reform) through an exchange during a special enrollment period or annual open enrollment period, you can elect to cancel Employer-provided group health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your Employer-provided group health coverage is revoked.

FMLA Leaves

If you go on an FMLA leave, you may continue or revoke your elections regarding group health coverage and/or your health care spending account even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

- Generally, the maximum FMLA leave period is 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if you take an FMLA leave to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

- You may continue or revoke your election of these benefits when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact Employer to discuss the procedures for making the contributions.

- If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately-- no pre-existing condition provision will apply.

- You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

- If you take an unpaid FMLA leave and you receive additional Compensation from Employer for waiving medical coverage, you will not receive this additional Compensation for the time period when you are on the unpaid leave.

- If you terminate coverage in your health care spending account during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. Also your total benefits during the plan year may

be reduced on a pro rata basis for the time period in which your coverage was not in effect.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate.

Special Enrollment Rights Under HIPAA

You may have special rights under HIPAA to enroll in Employer's group health plan in these situations:

- You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under Employer's group health plan. ("CHIP" is a state children's health insurance program.) You must make your new election within 60 days after the event occurs.

Court Order

You may change your election regarding Employer's group health plan because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the Employer-provided health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under Employer's group health plan. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under Employer's group health plan.

Cost and Coverage Changes

If the cost of coverage under Employer's group health plan or one of Employer's other insurance plans in which you participate changes during the plan year, your compensation reductions will automatically be adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

With respect to your dependent care spending account, if the cost of your dependent care provider changes during the plan year you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If coverage under Employer's group health plan or one of Employer's other insurance plans in which you participate is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. Further, if Employer offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent have a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under this Plan.

YOUR INSURANCE BENEFITS

If you elect to receive health and/or welfare coverage under Employer's group insurance plan(s), your pay will be reduced by the amount stated in your election. Your premiums under Employer's group insurance plan(s) will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you must make arrangements with Employer to pay your share of the premiums in order to continue coverage.

Health and welfare benefits under Employer's group insurance plan(s) will be paid according to each plan's claims procedure. If your claim for benefits under one of Employer's group insurance plan(s) is denied, in whole or in part, you may appeal according to that plan's appeal procedure. The existence of this Plan will not cause Employer to guarantee benefits under any of its group insurance plan(s). Benefits under a group insurance plan will be exclusively provided under that plan. If there is any conflict or inconsistency between the description of benefits contained in this Plan and the description of benefits contained in one of Employer's group insurance plans, the terms of the group insurance plan will control.

YOUR FLEXIBLE SPENDING ACCOUNTS

There are certain health care expenses that you or your family may incur that are not covered under Employer's group insurance plan(s). Also, if you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these health care and dependent care expenses under your flexible spending accounts. Your flexible spending accounts allow you to pay certain qualifying expenses using "before-tax" income rather than "after-tax" income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The flexible spending accounts operate as follows. Employer will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit you choose for a plan year. For example, if you choose both of the tax-free reimbursement benefits available under the Plan, Employer will establish the following accounts in your name:

- Health care spending account; and
- Dependent care spending account.

Employer will allocate your pay reductions to each account in the amount indicated in your election. When a claim for reimbursement is paid, the amount paid will be subtracted from the applicable flexible spending account. You may not use amounts allocated to one account to receive reimbursement for another type of benefit.

Health Care Spending Account

What Amount of Pay Reductions Should I Allocate to My Health Care Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your health care spending account and, if so, how much to reduce your pay. However, the maximum amount you may have credited to your health care spending account for a plan year is set forth in the last section of this Summary Plan Description. Beginning as of January 1, 2021, federal law does not allow you to contribute more than $2,750 to your health care spending account per plan year. This amount may be adjusted in future plan years for changes in the cost of living.

If you know you will have qualifying health care expenses during the plan year which will not be covered by Employer's group insurance plan or by any other source, you should consider putting enough in your health care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying health care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount to put in your health care spending account, it is wise not to put in too much. Federal law generally does not allow you to withdraw any

unused amounts or to carry them over to the next plan year. However, at the end of the plan year, up to $550 of any unused amount may be carried over to the next plan year. At the end of the Plan Year, all unused amounts in excess of $550 must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Health Care Spending Account?

Qualifying Individuals

Your qualifying health care expenses may be reimbursed under the Plan. Qualifying health care expenses may be incurred for:

- You;
- Your legally married spouse (of the same or opposite gender);
- Your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through December 31 of the calendar year the child turns age 26; or
- Other children, relatives and members of your household who are your "qualifying child" or "qualifying relative" under IRS guidelines.
    - A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18 or 23 (if a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled; or
    - A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual's financial support and the individual is not the qualifying child of you or any other individual.

Qualifying Health Care Expenses

Qualifying health care expenses are generally those types of health care expenses normally deductible on your federal tax return (without regard to

the adjusted gross income limitation which is generally 10%). They include, for example, expenses you have incurred for:

- Copays and deductibles you must pay before your group health plan begins to pay benefits.
- Vaccines, medicine and drugs that require a prescription (e.g., birth control pills, vitamins, etc.).
- Over-the-counter drugs and medicines, regardless of whether the medicine or drug is prescribed by a physician.
- Medical supplies such as bandages and crutches.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (health care only).
- Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition.
- Menstrual care products (tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation or other genital-tract secretions).
- Lasik (laser) eye surgery.
- Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed as a qualifying health care expense. However, housework may qualify for reimbursement under your dependent care spending account.
- Hospital care (including meals and lodging), clinic costs and lab fees.
- Medical treatment at a center for the treatment of alcohol or other substance abuse.
- Medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, wheelchairs, guide dogs and the cost of maintaining these aids.

- Ambulance service and other travel costs to get health care. If you used your own car, you may claim what you spent for gas and oil to go to and from the place you received the care, or you may claim the mileage reimbursement allowed by federal law. You may add parking and tolls to the amount you claim under either method.

- Expenses for weight-loss programs as treatment for obesity. This includes the fees to join the program, but not the cost of food.

- Massage therapy prescribed by a physician to treat a medical condition.

- Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors and on-site health fairs that check items like blood pressure and cholesterol.

- Teeth whitening to correct discoloration caused by disease, birth defect or injury.

- Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future (but not if storing it just in case of a future need).

Many of the expenses listed above are covered by Employer's group insurance plan(s). Any expense covered by Employer's group insurance plan(s) or any other source will not be treated as a qualifying health care expense under the Plan.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, orthodontia services may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.

Special Rule for Health Savings Account Participants

A health savings account ("HSA") is a tax-favored IRA type of account established for an eligible individual only covered by a qualified high deductible health plan. If you are enrolled in Employer's high deductible health plan and you contribute to an HSA (or Employer contributes for you), you may not receive coverage under a non-high deductible health plan. If you have coverage under a non-high deductible health plan, you are ineligible for the HSA.

A health care spending account is generally considered a non-high deductible health plan for this purpose. However, the health care spending account will not be treated as a non-high deductible health plan if the individual may only be reimbursed under the health care spending account for uninsured dental and vision care expenses, preventive care (such as annual physicals and routine well-child care, related tests and immunizations, and tobacco cessation and obesity weight loss programs) and other expenses incurred after the minimum annual deductible under the high deductible health plan is satisfied. This is known as a "limited purpose health care spending account."

The health care spending account portion of the Plan contains this restriction for a plan year for you and your dependents, as of the first day of the plan year as of which you are covered by the health care spending account portion of the Plan and are enrolled in Employer's high deductible health plan and you contribute to an HSA established by Employer (or if Employer contributes to the HSA for you). By limiting reimbursements from the health care spending account in this manner, you will not lose HSA eligibility. These limitations apply to you and your dependents.

Please note that if you are eligible for an up to $550 carryover of unused amounts to the next plan year and you enroll in Employer's high deductible health plan for that subsequent plan year, you will only be eligible to submit claims for the carryover that qualify under the limited purpose rules. Again, this is to ensure your HSA eligibility.

Please note that if you are eligible for an up to $550 carryover of unused amounts to the next plan year and you enroll in Employer's high deductible health plan for that subsequent plan year, you will only be eligible to submit claims for the carryover that qualify under the limited purpose rules. Again, this is to ensure your HSA eligibility.

Special Rule for Participants Called to Active Military Service

If you are called to active military service for a period of at least 180 days, you may take a "qualified reservist distribution" from your health care spending account in accordance with a federal law known as the HEART Act. In order to obtain a distribution you must provide Employer with a copy of your active duty order and make the request in writing before the end of the year in which you are called to active duty. The amount of the distribution may not exceed the current unused balance in your health care spending account at the time the distribution is processed. The distribution will be included in your taxable income. The distribution request will be processed as soon as administratively feasible and in no event later than 60 days from the date the request was submitted.

Non-Qualifying Expenses

You **cannot** obtain reimbursement for the following expenses:

- The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain coverage under Employer's group insurance plan(s) or for the premium your spouse pays to obtain health coverage under his or her employer's group insurance plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you may purchase coverage under Employer's group insurance plan under other provisions of the Plan (see the "BENEFIT CHOICES" section above).
- Life insurance or income protection policies.
- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax.
- Illegal operations or drugs.
- Items which are considered toiletries (such as toothpaste) or cosmetics (such as face cream).
- Travel your doctor told you to take for rest or change.
- Items purchased for cosmetic reasons.
- Cosmetic surgery, unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease.
- Long-term care expenses.
- Health club dues.
- Expenses reimbursed by Employer's group insurance plan(s) or any other source.
- Expenses incurred before you begin, or after you stop, making contributions to your health care spending account.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of qualifying health care expenses to Employer or the benefit administrator (see the last section of this Summary Plan Description). You will need to provide the information required on the claim reimbursement form furnished by Employer or the benefit

administrator. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the expense was paid.

Your health care spending account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur $100 of qualifying health care expenses during the first month of the plan year, you may be reimbursed for those expenses immediately, even if you only have $50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your health care spending account for the plan year (plus any carryover amount – see below). Also, only claims for qualifying expenses will be reimbursed.

Reimbursement checks are issued as soon as administratively feasible after Employer or the benefit administrator receives the claim, but in no event less frequently than monthly. At the end of the plan year, all claims will be paid to the extent of the balance in your health care spending account.

Claims for expenses incurred during a plan year may generally only be reimbursed out of your account balance for that plan year (subject to the carryover rule described below). All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. Further, if you terminate employment and your participation in the Plan before the end of a plan year, all claims for reimbursement must be turned in no later than the end of the time period set forth in the last section of this Summary Plan Description. If you do not turn in a claim by the required date, the claim will be denied. Any amount then remaining in your account may be forfeited (see the "Forfeitures" subsection).

Your health care spending account is not insured. If for any reason the Plan or Employer does not ultimately reimburse you for expenses that are eligible for reimbursement under the Plan, you may be liable for the expenses.

The benefit administrator's duty is to process claims. The benefit administrator will not insure that any of your expenses will be reimbursed. The benefit administrator will promptly process claims you make. However, if there are delays in processing claims, you have no greater rights to interest or other remedies against the benefit administrator or Employer than you otherwise have by law.

Carryover Rule

Under the carryover rule, if you are a participant in the Plan at the end of the plan year and you have an unspent balance in your health care spending account at the end of the plan year and end of the 90 day claims submission period the balance,

up to a maximum of $550, may be carried over and used to pay for qualifying health care expenses incurred in the following year. However, you only have access to the carryover amount for a maximum of one plan year. Thereafter, the unused portion of the carryover is forfeited. Please remember that if you are enrolled in the Employer's high deductible health plan for the following year, you may only use the carryover for limited purpose in order to ensure your HSA eligibility.

HIPAA Privacy

The health care spending account is subject to the HIPAA privacy rules. You will receive a notice of Employer's privacy practices which will explain, in detail, the HIPAA privacy rules and your privacy rights.

Dependent Care Spending Account

What is the Difference Between My Dependent Care Spending Account and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "before-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (currently up to $3,000 for one child and up to $6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you wish to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year, all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Dependent Care Spending Account?

Your dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by Employer.

The Internal Revenue Code defines who is considered your dependent for this purpose:

- Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

- Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:

    - Your qualifying child under age 13; or

    - Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

    - Under age 13; or

    - Totally disabled (as defined above) and regularly spends at least eight hours per day in your home.

    This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook), as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you wish to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;
- Your spouse; or
- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Plan. Generally, the limit is $5,000 per year (or $2,500 if you are married and file a separate tax return).

However, if you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or
- $500, if you have dependent care expenses for more than one dependent.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of qualifying dependent care expenses to Employer or the benefit administrator (see the last section of this Summary Plan Description). You will need to provide the information required on the claim reimbursement form furnished by Employer or the benefit administrator. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the expense was paid.

You should send your claims for reimbursement of dependent care expenses to Employer or the benefit administrator (see the last section of this Summary Plan

Description). You will need to provide the information required on a claim reimbursement form furnished by Employer or the benefit administrator. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441. However, if the entity is a tax-exempt organization described in Section 501(c)(3) of the Internal Revenue Code, you must indicate that the entity is tax-exempt, rather than providing its taxpayer identification number.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement checks are issued as soon as administratively feasible after Employer or the benefit administrator receives the claim, but no less frequently than monthly. At the end of the plan year, all claims will be paid to the extent of the balance in your dependent care spending account.

Claims for dependent care expenses incurred during a plan year may only be reimbursed out of your account for that plan year. All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. Further, any amount remaining in your dependent care spending account at the time of your termination of participation may only be applied toward the reimbursement of claims for eligible dependent care expenses incurred through the date your participation terminated. Further, if you terminate employment and your participation in the Plan before the end of a plan year, all claims for reimbursement must be turned in no later than the end of the time period set forth in the last section of this Summary Plan Description. If you do not turn in a claim by the required date, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" section).

Your dependent care spending account is not insured. If for any reason the Plan or Employer does not ultimately reimburse you for expenses that are eligible for reimbursement under the Plan, you may be liable for the expenses.

The benefit administrator's duty is to process claims. The benefit administrator will not insure that any of your expenses will be reimbursed. The benefit administrator will promptly process claims you make. However, if there are delays in processing claims, you have no greater rights to interest or other

remedies against the benefit administrator or Employer than you otherwise have by law.

Other Rules Regarding Your Flexible Spending Accounts

Termination of Participation

If you terminate employment or otherwise become an ineligible participant under the Plan, you will be ineligible to have any additional pay reductions under the Plan credited to your health care spending account or dependent care spending account. If you have amounts remaining in your accounts, you may continue to turn in claims for reimbursement of expenses incurred before you terminated employment. However, all such claims must be turned in no later than the end of the time period set forth in the last section of this Summary Plan Description. With respect to your health care spending account, you will not be eligible to be reimbursed for claims for reimbursement of expenses incurred after you terminated employment, except as explained in the next paragraphs.

You have the option of continuing to participate in your health care spending account after you terminate participation to the extent required by the federal law known as "COBRA." Where Employer is subject to COBRA, if the amount contributed to your health care spending account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to continue to participate for the remaining portion of the plan year during which your participation terminated. COBRA is generally not available for a subsequent plan year unless, pursuant to federal regulations, certain requirements are met (e.g., your health care spending account is not considered an excepted benefit under HIPAA).

If you are eligible to elect COBRA with respect to your health care spending account, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the pay reductions which were allocated to your health care spending account each month before you terminated participation. After-tax contributions for a month are due on the first day of that month. However, there is a 30-day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

In order to protect your rights to COBRA, it is important that you inform the Plan Administrator of any changes in your address. If you have questions regarding COBRA, you should contact the Plan Administrator at the address and telephone number listed in this Summary Plan Description.

For more information about your rights under the Employee Retirement Income Security Act of 1974 ("ERISA"), including] COBRA, HIPAA and other laws affecting the Plan, you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA's website at www.dol.gov\ebsa.

(Addresses and telephone numbers of the regional and district offices are available through EBSA's website.)

If you participate in the health care spending account and go on a military leave of absence, Employer will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than under COBRA (i.e., coverage for a longer period of time or less costly coverage).

Forfeitures

Your pay reductions for each plan year may generally only be used to reimburse qualifying expenses incurred during that plan year pursuant to the carryover rule. For purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided.

Federal law requires the forfeiture of amounts left after reimbursing expenses incurred during the plan year. A forfeiture will occur if you fail to use the entire amount in your health care spending account and dependent care spending account. (This is subject to the carryover rule for your health care spending account, as described in the "Carryover Rule" subsection.) You are not allowed to transfer unused amounts from one spending account to another spending account. You should be careful not to overestimate your expected expenses when you turn in your election form. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.

Appeal Procedure

If your claim for benefits under the flexible spending accounts has only been partially reimbursed or denied, you will be given notice of the nonpayment or denial. The notice will be given within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that you are notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you will be granted 45 days from the receipt of the notice within which to provide the information. The Plan's period for making the benefit determination will be the 15-day period beginning on the date it receives this additional information.

If you do not provide the additional information within 45 days from the receipt of the notice of the extension, the Plan may issue a denial of the claim within 15 days after the end of the 45-day period.

Notification of any adverse benefit determination will set forth the specific reason or reasons for the adverse benefit determination, refer to the specific Plan provisions on which the determination is based, and describe any additional material or information necessary for you to perfect the claim. The notice will also describe the Plan's review procedures and related time limits and a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review. If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a copy will be provided to you free of charge upon request.

You may request a review of any adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. You may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, 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.

The appeal procedure will provide for a review that does not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual.

The Plan Administrator will notify you of the Plan's determination on review within 60 days after the Plan's receipt of your request for a review of an adverse benefit determination. If adverse, the notice will include the same information which must be included in the notification of the initial adverse benefit determination.

The Plan will not be required to pay interest on any claim for benefits, regardless of when paid. Also, if a check for the payment of Plan benefits is not cashed within one year after the date it is issued, the check will be dishonored.

YOUR HEALTH SAVINGS ACCOUNT

What is a Health Savings Account?

A health savings account is a tax-favored IRA-type account established for an eligible individual covered under a qualified high deductible health plan. Contributions to a health savings account are fully vested when made and investment earnings on the account grow tax-free. Distributions from the health savings account are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years.

The health savings account benefit is included in the Flexible Benefit Plan because this Plan provides a mechanism for contributions to be made to your account. If permitted by Employer, you may elect to have before-tax pay reductions contributed to your health savings account. In addition, Employer may make an Employer contribution on your behalf to your health savings account. The amount, if any, provided by Employer will be based on a formula determined by Employer which is permissible under the Internal Revenue Code and communicated to you during the open enrollment period.

Who is Eligible to Participate in a Health Savings Account?

You are eligible to participate in the health savings account portion of the Plan if you are an "eligible individual." An eligible individual must be covered under a high deductible health plan that satisfies the requirements of federal law, including having an annual deductible of at least a certain amount. The amount is set by the federal government and may be adjusted each year for changes in the cost of living. An eligible individual also cannot be enrolled in any other health plan that does not qualify as a high deductible health plan.

When is my Participation in the Health Savings Account Effective?

Your participation in the health savings account portion of the Plan will begin on the first day of the month on or after the later of the effective date of the health savings account or the date you became a participant in the Plan (see the "PARTICIPATION" section).

When will my Participation in the Health Savings Account End?

If you terminate employment or otherwise become ineligible to participate in the health savings account portion of the Plan, your participation will generally terminate as of the last day of the month during which you are no longer an eligible participant in the Plan.

What are the Election Procedures?

The same election of benefit rules (see the "CHOOSING YOUR BENEFITS" section) generally apply to the health savings account portion of the Plan. If you do not make an election before the required date, no pay reductions, if applicable, will be credited to your health savings account as of your initial date of participation (initial election) or as of the first day of the next plan year (subsequent annual election). However, pay reductions to your health savings account may be made starting as of a subsequent date in accordance with procedures established by the plan administrator. However, Employer may still make Employer contributions, if applicable, to your health savings account.

You may elect to change the amount of your pay reductions, if applicable, to your health savings account on at least a monthly basis as of any prospective date which is in accordance with the procedures established by the plan administrator. The mid-year election change restrictions (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section) do **not** apply to your health savings account contributions.

What are the Other Important Rules Concerning the Health Savings Account and High Deductible Health Plan?

Remember, the health savings account benefit is included in the Flexible Benefit Plan because this Plan provides a way for contributions to be made to your account. As a result, the other rules concerning the health savings account and high deductible health plan are not part of this Plan but will be provided to you in the communications materials regarding the health savings account and high deductible health plan benefits.

ADMINISTRATION

Employer is the plan administrator. The plan administrator is charged with the administration of the Plan. The plan administrator has the authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The plan administrator will exercise its discretionary authority in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the plan administrator has the discretionary authority to interpret the terms of the Plan.

FUTURE OF THE PLAN

Employer intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan at any time. However, your pay reductions which occur before the amendment or termination will continue to be used for your benefit.

YOUR RIGHTS AS A PARTICIPANT

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA") for the portion of the Plan that is subject to ERISA (for example, the health care spending accounts).

Plan Information and Benefits

ERISA provides that all plan participants are entitled to:

- Examine, without charge at the plan administrator's office all Plan documents, including summary plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the plan administrator, copies of all Plan documents, including copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The plan administrator may make a reasonable charge for the copies.

Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

Enforcement of Rights

If your claim for reimbursement under the Plan 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 limits. See the "Appeal Procedure" subsection of this Summary Plan Description.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement ("YOUR RIGHTS AS A PARTICIPANT") or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing their website at www.dol.gov/ebsa.

OTHER BASIC INFORMATION ABOUT THE PLAN

Plan Name:	Schupan & Sons, Inc. Flexible Benefit Plan
Name, Address and Telephone Number of Employer/Plan Sponsor: Plan Administrator Information	Schupan & Sons, Inc. 2619 Miller Road Kalamazoo, MI 49003 (616) 382-0000
Taxpayer Identification Number of Employer/Plan Sponsor:	38-2116904
Plan Number:	501
Type of Plan:	Flexible Benefit Plan
Type of Administration:	Administered by Plan Administrator and Benefit Administrator.
Plan Administrator:	Employer is the Plan Administrator.
Name, Title and Address of Agent for Service of legal process:	Schupan & Sons, Inc. 2619 Miller Road Kalamazoo, MI 49003 Service of process may also be made on the Plan Administrator.
Name, Address and Telephone Number of Benefit Administrator:	Flex Administrators, Inc. 3980 Chicago Drive, SW, Suite 230 Grandville, MI 49418 (616) 456-7908
Plan Year:	January 1 – December 31
Related Participating Employers:	N/A
Maximum amount a participant may annually allocate to his or her health care spending account:	$2,750.00
Grace period to submit claims under health care spending account upon termination of employment:	90 days

If employee terminates employment and participation in Plan before the end of a plan year, all claims for reimbursement under the health care and dependent care spending accounts must be turned in no later than:	90 days