SUMMARY PLAN DESCRIPTION
for the
Presbyterian Homes & Services
Salary Reduction Plan

Presbyterian Homes & Services is pleased to announce that it has established a Salary Reduction Plan, also called a "Cafeteria Plan" for eligible Employees. Under this program you will be able to select health coverage and other benefits as described in this Plan. Plan participation will reduce the amount of your taxable Compensation. Accordingly, there may be a slight decrease in your Social Security benefits and/or other benefits (e.g., 401(k), pension, disability and life insurance) which may be based upon taxable Compensation.

The Employer cannot guarantee that specific tax consequences will not occur from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit.

This Summary Plan Description describes the basic features of the Plan, its limitations, and how it operates. This booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. If there is a conflict between the official plan documents and this booklet, the plan documents will apply.

Please refer to the official plan documents for applicable meanings when words/phrases are capitalized, and the word/phrase is not defined in this booklet.

GENERAL INFORMATION

a) **Name of the Plan**: Presbyterian Homes & Services Inc. Salary Reduction Plan (Plan).

b) **Type of Plan**: Welfare plan providing Premium Payment Component, Health FSA Component and DCAP Component.

c) **Plan Number**: 501.

d) This Plan becomes effective on April 1, 2015 as restated. Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended.

e) **Plan Year.** The Plan records are kept on a twelve-month period, which is called the Plan Year. The Plan Year begins on April 1, 2015 and ends on March 31, 2016. Subsequent Plan Years begin on April 1st and end on March 31st.

f) **Employer/Plan Sponsor**

Name:	Presbyterian Homes & Services, Inc.
Address:	2845 Hamline Avenue North Roseville, MN 55113
Telephone Number:	(651) 631-6144
Tax I.D. Number:	41-1463801

g) **Plan Administrator**. A Plan Administrator has been appointed to keep Plan records and manage the Plan. The Plan Administrator will also answer any questions you may have regarding the Plan, and will make a copy of Plan documents available to you upon request. Information regarding the Plan Administrator is as follows:

Name: Presbyterian Homes & Services, Inc.
Contact Executive Director of Human Resources
Address: 2845 Hamline Avenue North
Roseville, MN 55113
Telephone Number: (651) 631-6144

h) **Service of Legal Process**

Name: Presbyterian Homes & Services, Inc.
Address: 2845 Hamline Avenue North
Roseville, MN 55113
Telephone Number: (651) 631-6144

i) **Funding Medium and Type of Plan Administration.** The Health FSA Component is a group health plan. The Health FSA Component is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan. The cost of administration of the Plan is paid in part by the use of forfeitures, if any. The balance of the cost of administering the Plan is paid entirely by the Employer.

j) **Claims Administrator**. Optum Bank is the Plan's Claims Administrator. Optum Bank is contracted to provide clerical and claim processing services to the Plan and is not financially responsible or obligated for the funding of claims processed under the Plan, nor is Optum Bank a fiduciary to this Plan.

ELIGIBILITY

You shall be eligible to participate in the Plan if you meet the following requirements: (1) you are an active fulltime Employee working 30 or more hours per week and you have worked for Presbyterian Homes & Services for at least one full month; (2) you meet the definition of Employee as stated below; and (3) you are at least 18 years of age. Your participation will begin on the first day of the month following satisfaction of eligibility requirements.

EMPLOYEE - means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include **the** following: (A) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer, (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or

others to be a common-law employee of the Employer, (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employer by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Those Employees who actually participate in the Plan are called Participants. An Employee continues to participate until (i) the end of the Plan Year for which the election was made, unless the Participant elects during an annual Open Enrollment Period to continue participation; (ii) the termination of the Plan; (iii) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) or (iv) the Participant revokes his election in accordance with the terms found in the official plan document, whichever occurs first. Note: For purposes of pre-taxing COBRA coverage, certain Employees may be able to continue eligibility for certain periods.

BENEFITS

The various benefits available to you under the Plan include the following:

a) Premium Payment Component (i.e., for plans offered by the Employer, such as, medical, dental and health savings account (HSA) etc.);

b) Health FSA Component for: (i) Full Purpose Health FSA, Limited Purpose FSA Option; and

c) DCAP Component.

This booklet does not provide all the details of the Plan. See your Plan Administrator for further details.

From time to time, the Employer, in its sole discretion, may add or delete components from the Plan. The Plan Administrator will notify you of any such changes.

ELECTIONS

Participation

You become a Participant by signing an individual Compensation Reduction Agreement (Election Form) in which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits. You will be provided with an Election Form when you first become eligible to participate. You must complete the form and return it to the Employee Benefits Manager within the time period specified by the Plan Administrator. If you do not elect coverage when you are first eligible, you must wait until the next Open Enrollment Period to enroll for the following year, except for a Change in Status event.

A new Election Form will be made available to you before the first day of the Open Enrollment Period, and you will be given the opportunity during this period to elect your coverage for the 12 months

beginning on the next April 1st. This 12-month period is called the Plan Year. The Open Enrollment Period for a Plan Year will generally be in March.

The maximum Contribution to the Premium Payment Component in any Plan Year is the Employee-paid premiums. Maximum Contributions to the Presbyterian Homes & Services, Inc. Health FSA Component and DCAP Component are shown and limited as stated in this booklet.

Failure to Elect
If an Employee fails to notify the Plan Administrator of his election for the Plan Year in which the Employee is first eligible, such Employee shall have been deemed to elect to receive his Compensation in cash.

Elections for Premium Payment Component
In any plan year in which a new benefit option is offered or a Participant wishes to change the benefit option in which they are currently enrolled, she/he must complete, sign and return an Election Form as required by the Employer. In subsequent Plan Years, if a Participant fails to complete, sign and return an Election Form as required, she/he shall be deemed to have elected to continue participation in the Premium Payment Component only. The Participant's Premium Payment Component election will be for the same benefit option as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and (except for a Change in Status) she/he will not be permitted to modify the election until the next Open Enrollment Period.

Elections for Medical and DCAP
Annual elections for participation in the Medical and DCAP Components **MUST** be made by submitting an Election Form prior to the beginning of each Plan Year—no deemed elections shall occur with respect to such benefits.

Change in Election
Generally, you cannot change your election to participate in the Plan or vary the Compensation Reduction amounts you have selected during the Plan Year. You may change your elections only during the Open Enrollment Period, and then, only for the upcoming Plan Year.

There are several important exceptions to this general rule. You may change or revoke your previous Compensation Reduction amount during the Plan Year if you file a written request for a change with the Plan Administrator within 31 days (or within 60 of a birth/adoption) of any of the following events:

a) **Change in Status**. If there is a Change in Status, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with a Change in Status that affects the coverage eligibility of you, your Spouse, and/or your Dependent. Change in Status events are limited to the following:

(1) *Legal Marital Status*. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment.

(2) *Number of Dependents*. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption.

(3) *Employment Status*. Any of the following events that change the employment status of the Participant or his Spouse or Dependents: (1) a termination or

commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa);

(4) *Dependent Eligibility Requirements*. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstances; and

(5) *Change in Residence*. A change in the place of residence of the Participant or his Spouse or Dependents; and

(6) Other events included under subsequent changes to the Code.

If a Change in Status event occurs, you must inform the Plan Administrator and complete a new Election Form within 31 days of the event (or within 60 of a birth/adoption). You must also establish that the change in election is on account of and consistent with the Change in Status event. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and consistent with a Change in Status.

b) **Changes in Coverage Attributable to Spouse's Employment**. If there is a significant change in your or your Spouse's health coverage, which is attributable to your Spouse's employment, you may change your election under the Plan provided that the new election is consistent with the change in coverage.

NOTE: Mid-year election changes are subject to the minimum/maximum stated in the official Plan documents.

c) **Special Enrollment Rights**. If you, your Spouse and/or your Dependent(s) are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Please refer to the group health plan description and this Plan's official Plan document for a further explanation of your special enrollment rights. This change does not apply to the Health FSA Component unless such component is subject to HIPAA.

d) **Certain Judgments, Decrees and Orders**. If a judgment, decree or order resulting from a divorce, separation, annulment or custody change requires your child to be covered under this Plan, you may change your election to provide coverage for the child. If the order requires that your former Spouse to cover the child, you may change your election to revoke coverage for the child **ONLY** if your former Spouse actually obtains coverage for your child.

e) **Entitlement to Medicare or Medicaid**. If you, your Spouse, or your Dependent(s)

become entitled to Medicare or Medicaid, you may reduce or cancel that individual's coverage under the Employer sponsored group health plan. This change does not apply to the Health FSA Component.

f) **Significant Changes in Cost or Coverage.**

***Please Note: The following changes do not apply to the Health FSA Component*.**

(1) If the Plan Administrator determines that the cost of your benefit plan(s) or policy(ies) has significantly increased or coverage has been significantly curtailed during a Plan Year, you may make a corresponding prospective increase in your contribution(s) or revoke your prior election and elect coverage under another health option with similar coverage, provided that you notify the Plan Administrator within 31 days of receiving written notice of the change. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an increase/curtailment is "significant", and whether a substitute benefit plan or policy constitutes "similar coverage" based upon all surrounding facts and circumstances.

The above Change in Cost provision applies to the DCAP Component only if the cost change is imposed by a Dependent care provider who is not a relative of the employee by blood or marriage (as that term is defined in Proposed Treas. Reg. Sec. 1.125-4(f)(2)(iii) or other IRS guidance).

(2) If a plan adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a Plan Year, you may either revoke your election under the Plan or in lieu thereof, make an election for coverage on a prospective basis for coverage under the new or improved benefit package option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether the increase/decrease in cost(s) is "significant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(3) The Plan will permit you to make an election on a prospective basis to add coverage under the Plan for you, your Spouse, or Dependent if you, your Spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

i. a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;
ii. a medical care program of an Indian Tribal government (as defined in Sec. 7701 (a) (40)), the Indian Health Service, or a tribal organization;
iii. a state health benefits risk pool; or
iv. a foreign government group health plan.

g) **Automatic Election Changes**. The Plan Administrator may modify your election(s) during the Plan Year if you are a Key Employee or Highly Compensated Employee (as defined by the Code), if such change is necessary to prevent the Plan from becoming discriminatory within the meaning of Federal income tax law. Adjustments may also be made to reflect insignificant mid-year premium increases imposed by third party insurers.

All changes in elections/new elections shall be effective **prospectively** (e.g., your first pay period following the date you returned the Election Form to the Plan Administrator).

Family and Medical Leave Act
If your Employer is subject to the Family and Medical Leave Act (FMLA) and if you are eligible for leave under FMLA, then you may continue to pay for your group health coverage on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis before the leave begins). If your Employer pays a portion of your group health premiums, then it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the group health premiums. If your Employer is subject to FMLA, then you should be provided with a complete explanation of your FMLA rights and responsibilities.

Non-FMLA Leaves of Absence
If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on unpaid leave that does affect eligibility, then the Change in Status rules will apply.

Termination of Employment
If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more Contributions to the Plan. See the COBRA provision below and in your Employer sponsored group health plan for more information on your right to continued coverage after termination of your employment.

New Election
If you are rehired within the same Plan Year but more than 30 days after you terminated employment, you may make new elections, provided that you are eligible to participate in the Plan.

Reinstatement
If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

NOTE: If an Employee is rehired in the Plan Year following the plan year in which he terminated and he has satisfied the eligibility requirements of the Employer sponsored group health plan, he will be allowed to make a new election.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your coverage under this Plan. It can also be available to your spouse and Dependent children, if they are covered under the Plan, when they would otherwise lose their coverage under this Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Coverage? COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". You, your spouse, and your Dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries.

Who is Entitled to Elect COBRA? If you are an Employee, you will be entitled to elect COBRA if you lose your coverage under this plan because either one of the following qualifying event happens:

a) Your hours of employment are reduced; or

b) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will be entitled to elect COBRA if you lose your coverage under this Plan because of any of the following qualifying events happens:

a) Your spouse dies;

b) Your spouse's hours of employment are reduced;

c) Your spouse's employment ends for any reason other than his or her gross misconduct; or

d) You become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your coverage under this Plan in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the Employee's Dependent child will be entitled to elect COBRA if he or she loses coverage under this Plan because any of the following qualifying events happens:

a) The parent-Employee dies;

b) The parent-Employees hours of employment are reduced;

c) The parent-Employee's employment ends for reason other than his or her gross misconduct;

d) The child's ceases to eligible for coverage under the Plan based on the Plan's definition of a Dependent child.

When is COBRA Coverage Available? When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these qualifying events.

You Must Give Notice of some Qualifying Events. For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child) a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of:

a) The date of the qualifying event; and

b) The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

In providing this notice, you must follow the notice procedures specified under the section entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided to the Plan Administrator during the 60-day notice period, **THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA**.

Electing COBRA Each qualified beneficiary will have an independent right to elect COBRA. Covered Employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA**.

Mail, hand-deliver or fax the completed Election Form to:

OptumHealth Financial Services, Inc.
COBRA/Eligibility Department
PO Box 740221
Atlanta, GA 30374
www.adminservices.optumhealthfinancial.com

How Long Does COBRA Coverage Last? COBRA coverage under Health FSA Component will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered Employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA Component COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage will consist of the Health FSA Component coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). Any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA Component will be covered together for Health FSA Component COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA Component annual limit and a separate premium. If you are interested in this alternative, contact the Plan

Administrator for more information.

More Information About Individuals Who May Be Qualified Beneficiaries - Alternate recipients under QMCSOs A child of the covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during the covered Employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

Keep Your Plan Informed of Address Changes In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions Questions concerning your Plan or your COBRA rights should be addressed to the Plan contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting this Plan, 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 website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Plan Contact Information You may obtain information about the Plan and COBRA coverage on request from:

The Employer (Plan Administrator):

Presbyterian Homes & Services Inc.
2845 Hamline Avenue North
Roseville, MN 55113
(651) 631-6144

COBRA Administrator:

OptumHealth Financial Services, Inc.
COBRA/Eligibility Department
PO Box 740221
Atlanta, GA 30374
www.adminservices.optumhealthfinancial.com

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.

Notices Must Be In Writing: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When and Where to Send Notices: You must mail or hand deliver your notice to:

Presbyterian Homes & Services Inc.
Human Resource Department
2845 Hamline Avenue North
Roseville, MN 55113

If mailed, your notice must be postmarked no later than the last day of the applicable period. If hand delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraph above entitled “Your Must Give Notice of Some Qualifying Events”.)

Information Required for All Notices: Any notice your provide must include: (1) the name of the Plan (Presbyterian Homes & Services Flex Plan); (2) the name and address of the Employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your coverage under this Plan was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Who May Provide Notices: The covered Employee (i.e., the Employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in this notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

RIGHTS UNDER ERISA

The Cafeteria Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act (ERISA). However, certain component benefits may be governed by ERISA. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About the Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls all documents governing the Plan, including contracts and collective bargaining agreements (if applicable), 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 Pension and Welfare Benefit Administration;

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage (and, in some cases, continue your Health FSA Component) for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

HIPAA Privacy Rights.

Under another provision of HIPAA, group health plans (including cafeteria plans) are required to take steps to ensure that certain “protected health information” (PHI) is kept confidential. You may receive a separate notice from the Employer that outlines its health privacy policies.

The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Executive Director of Human Resources
Employee Benefits Manager
Corporate Financial Officer

All PHI that is disclosed is used for the purposes of Plan operations.

Security Standards Requirement.
To comply with the Security Standards regulations that were published on February 21, 2003, the Company must:

a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

b) ensure that the adequate separation required by 45 C.F.R. Sec. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

d) report to the Plan any security incident of which it becomes aware.

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 benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim, all within certain time periods.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each Participant in an employee benefit Plan. Your booklet-certificate and this supplement are the Summary Plan Description for purposes of ERISA.

PREMIUM PAYMENT COMPONENT

If you elect Premium Payment Component benefits you will be able to pay for your share of contributions for coverage under your Employer group health plan with pre-tax dollars by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The only Premium Payment Component benefits offered under this Plan are for the Employer sponsored group health plan benefits.

If you select the Employer sponsored group health plan benefits, you may be required to pay a portion of the contributions. When you complete the Salary Reduction Agreement, when you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also know as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as a deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Component that you have selected.

HEALTH FSA COMPONENT

The Health FSA Component permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for medical care expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expenses from the group health plan).

If you elect the Health FSA Component, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible medical care expenses by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The Health FSA Component is intended to pay benefits solely for medical care expenses not reimbursed elsewhere. Accordingly, the Health FSA Component shall not be considered to be a group health plan for coordination of benefits purposes, and the Health FSA Component benefits shall not be taken into account when determining benefits payable under any other plan.

In the event that an expense is eligible for reimbursement under both the Health FSA Component and an HSA (Health Savings Account), you may seek reimbursement from either the Health FSA Component or the HSA, but not both.

There are numerous limitations placed on the terms of the Health FSA Component by federal law. The limitations affect, among other things, your maximum Contributions and the type of medical expenses that are reimbursable by the Plan. The Plan terms will change if federal law changes. The information below is based on the current provisions of the Internal Revenue Code.

You may choose any amount of medical care expense reimbursement that you desire under the Health FSA Component, subject to the minimum reimbursement amount of $60 and the maximum reimbursement amount of $2,650 per Plan Year. You will be required to pay the annual Health FSA Component contribution equal to the coverage level that you have chosen. If you are a Highly Compensated Employee or a Key Employee, your maximum Contributions may be lower, depending on your income and position in the Company. You will be advised if other limits apply to you.

If you elect benefits under this component of the Plan, a Health FSA account will be set up in your name to keep a record of your reimbursements, as well as the Contributions you have paid for such benefits, during the Plan Year. Your Health FSA account is merely a record-keeping account; it is not funded (all reimbursements are paid from the general assets of the Employer) and does not bear interest.

A Health FSA Component election may be for:

a) General-Purpose Health FSA Option.

Note: If you elect Health FSA you cannot also elect HSA benefits or otherwise make contributions to an HSA. If you are married and elect the General-Purpose Health FSA Option, your spouse will also be ineligible to make HSA contributions.

The eligible medical care expenses vary according to the type of Health FSA Component coverage option that is elected, as described below:

a) General-Purpose Health FSA Component Option. For purposes of the General-Purpose Health FSA Component coverage option, “medical care expense” means expenses incurred by your, your spouse, or your Dependents for “medical care” as defined in Code Section 213(d).

   If you continue to make the Contributions due for this benefit, the full annual amount of coverage that you have elected will be available at any time during the Plan Year. However, such amount will be reduced by the prior reimbursements received during the Plan Year. You cannot carry forward your Contributions from one Plan Year to the next Plan Year.

Medical Expenses must have been incurred during the current Plan Year. You may not submit claims for expenses for which you are eligible to receive reimbursement from another source, such as health insurance. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form takes effect, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for COBRA Coverage).

For more information about what items are – and are not – medical care expenses; consult your personal tax advisor.

NOTE: Over-the-counter (OTC) medicines and drugs will no longer be eligible under the Plan unless the Participant has a prescription from a licensed health care professional. OTC medicines and drugs include items such as Advil, Tylenol, allergy medicine, antacid, etc. Insulin and items that are not OTC medicines or drugs (band-aid, gauze, saline solution, reading glasses etc.) will continue to be eligible without a prescription.

Prescribed OTC medicines or drugs must be substantiated before reimbursement may be made under the Plan. Over the counter, (OTC) medicines or drugs may be substantiated in one of two ways:

a) Documentation by an independent third party that includes the name of the patient, the date and amount of the purchase and an Rx number. Example: a receipt from a pharmacy, which includes all of the required information.

b) Documentation by an independent third party with all required information except an Rx number plus a copy of the related prescription. Claims for OTC drugs will be denied if submitted without this information.

If you continue to make the Contributions due for this benefit, the full annual amount of coverage that you have elected will be available at any time during the Plan Year. However, such amount will be reduced by the prior reimbursements received during the Plan Year. You cannot carry forward your Contribution from one Plan Year to the next Plan Year with the exception of the Plan's $500 Carry Forward feature.

Medical expenses must have been incurred during the current Plan Year. You may not submit claims for expenses for which you are eligible to receive reimbursement from another source, such as health insurance. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form takes effect, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for COBRA coverage).

When you incur an expense that is eligible for reimbursement, you must submit a claim to the Claims Administrator on a claim form that will be supplied to you. You must include written statement(s), bill(s) or Explanation of Benefit Form(s) from an independent third party(ies) stating that the medical expense(s) has been incurred, and the amount of such expense(s). Remember, you may not submit claims for expenses for which you are eligible to receive reimbursement from another source, such as health insurance.

To have your claims processed as soon as possible, please read the claims instructions with which you have been furnished. Please note that it is not necessary for you to have actually paid the bill for

a medical expense—only for you to have incurred the expense. Remember, the reimbursements are limited to the annual reimbursement amount you have elected for that Plan Year.

If the Claims Administrator is unable to make payment to any Participant, to whom a payment is due under this Plan, because it cannot ascertain the identity or whereabouts of such Participants, after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments shall be forfeited after a reasonable time following the date any such payment first became due.

Any Health FSA Component account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited.

HEALTH FSA ACCOUNT $500 CARRY FORWARD FEATURE

Use-it or Carry Forward $500 - You are now able to roll over up to $500 into the next following plan year.

Carry Forward Amount
The amount that may be carried forward to the following plan year is **the lesser of**:

- Any unused amount from the immediately preceding plan year; or
- $500

Carry Forward Opt Out
If you are enrolled in an HSA plan or are enrolling in an HSA plan at this Open Enrollment Period you have the right to "Opt-Out" of the $500 carry forward. Since any carry forward that you may be eligible for will carry forward to the Plan's general purpose Health FSA Account it would prohibit you from contributing to an HSA account. To maintain eligibility to contribute to the HSA you must "opt-out" of the carry forward on your Open Enrollment forms as directed by the Plan Sponsor.

Any amount in excess of the $500 remaining at the end of the claim run-out period will be forfeited. Any amount remaining in an employee's health FSA as of termination of employment will also be forfeited.

The new carryover amount will not affect the $2,650 contribution limit. This means a participant may elect up to the full $2,650 in salary contribution in addition to the $500 that may be carried forward. A plan may reimburse claims incurred during the plan year up to the salary reduction limit of $2,550 plus the carryover amount of up to $500.

Keep in mind that the carryover amount can and will be used first for claims incurred in the new plan year. Any carryover amounts that are used to reimburse a current year expense will reduce the amounts available to pay prior plan year expenses during the run-out period.

Any amount allocated to an account which has not been carried forward shall be forfeited if it has not been used for reimbursement of eligible medical expenses by the 60th day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; to offset administrative expenses and future costs; and to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan

Administrator deems appropriate and consistent with applicable regulations, as provided in the official plan documents for this Cafeteria Plan.

DCAP COMPONENT

If you elect DCAP benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent care expenses by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

There are numerous limitations placed on the terms of Sec. 129 Dependent Care Plan by federal law. The limitations affect, among other things, your maximum Contributions, the type of service provided, who is considered a Dependent, and who may provide the care services.

The Plan terms will change if federal law changes. The information below is based upon the Internal Revenue Code.

Your maximum annual Contribution to the DCAP Component (when aggregated with all other Dependent care reimbursements during the same income tax year) is the lesser of: (1) $5,000 (or $2,500 if you are married and file a separate tax return); (2) your earned income for the tax year; or (3) the earned income of your Spouse. If your Spouse is a full-time Student or physically/mentally unable to care for himself/herself for any part of the tax year, you will be entitled to attribute income to your Spouse at the rate of $250 ($500 if you have two or more qualifying Dependents) for each month that your Spouse is a full-time Student or disabled. Your maximum Contribution is also limited by your Employer (refer to Schedule A).

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations (for example, note that you cannot exclude more than the amount of your or your spouse’s earned income for the calendar year).

There may be other limitations on your maximum Contribution depending upon your income, position in the Company, and the number of Participants in the Plan. You will be advised if these limitations apply to you.

If you elect benefits under this component of the Plan, a DCAP account will be set up in your name to keep a record of the reimbursements to which you may be entitled. Your DCAP account is merely a record-keeping account; it is not funded (all reimbursements are paid out of the general assets of the Employer) and it does not bear interest.

In order to be reimbursed for employment-related Dependent Care Expenses, the person who receives the dependent care services must be an individual whom you could claim as a dependent on your federal income tax return and who is either: (a) under the age of 13, or (b) physically/mentally unable to care for himself/herself. You may also be allowed to include employment-related Dependent Care Expenses for your Spouse if your Spouse is physically/mentally unable to care for himself/herself.

Generally, these expenses must meet all of the following conditions to be eligible Dependent Care Expenses:

a) If the expenses or household services are incurred for the care of an individual described above, the services/expenses must be incurred to enable you to be gainfully employed.

b) If the expenses are incurred for services outside your household, and such expenses are incurred for the care of a Spouse or other tax Dependent age 13 or older who is incapable of self-care, such individual must regularly spend at least eight hours per day in your home.

c) If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

In addition to the above, you cannot be reimbursed for Dependent Care Expenses if the individual providing the care is: (a) your child who is under age 19; or (b) any other individual that you or your Spouse is entitled to claim as a dependent for federal income tax purposes.

Amounts paid for food, clothing and education are not reimbursable expenses, unless they are incidental to and part of the care. You are encouraged to consult your personal tax advisor for further guidance as to what is an eligible expense.

If you elect to participate in this portion of the Plan, you will have to take certain steps in order to be reimbursed for your eligible expenses. When you incur an expense that is eligible for reimbursement, you must submit a claim to the Claims Administrator on a claim form that will be supplied to you.

Use if based upon deposits
If there are enough credits in your DCAP account, you will be reimbursed for your eligible expenses. If a claim is for an amount that is more than your current DCAP account balance, then the excess part of that claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, you cannot be reimbursed for any total expenses in excess of your available annual credits.

You may not be reimbursed for any expenses that arise before your Election Form is effective, or for any expense incurred after the close of the Plan Year

Ask the Plan Administrator if you need further information about which expenses are – and are not – likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you relay, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent care expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

a) your earned income for the calendar year (after your salary reductions under the Compensation Reduction Agreement plan);

b) the earned income of your spouse for the calendar year (your spouse will be deemed to have earned income of $250 ($500 if you have two or more qualifying individuals) for

each month in which your spouse is:

(1) physically or mentally incapable of self-care; or

(2) a full-time student; or

c) either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status.

The amount of DCAP Component benefit that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code Section 129 when your election is made. The $5,000 maximum will apply if:

(1) you are married and file a joint federal income tax return;

(2) you are married and file a separate federal income tax return, and meet the following conditions: (i) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP Component; (ii) you furnish over half of the cost of maintaining such household during the taxable year; and (iii) during the last six months of the taxable year, your spouse is not a member of such household (i.e., your spouse maintained a separate residence); or

(3) you are single or the head of the household for federal income tax purposes.

If you are married and reside with your spouse but you file a separate federal income tax return, then the maximum DCAP Component benefit that you may exclude from your income under Code Section 129 is $2,500 for a calendar year.

You cannot carry forward your Contributions from one Plan Year to the next Plan Year. If you are reimbursed for expenses from some other source, you cannot receive reimbursement from this Plan. Furthermore, you cannot take the Dependent Care Tax Credit (Form 2441 of Form 1040, or Schedule 2 of Form 1040A) on your federal tax return for any amounts that are reimbursed under this Plan. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any person who provided dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Any amount allocated to an account shall be forfeited and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the 60th day following the end of the Plan Year for which the election was effective. Forfeited amounts shall be used in a manner determined by the Plan Administrator, at its discretion.

If the Claims Administrator is unable to make payment to any Participant, to whom a payment is due under this Plan, because it cannot ascertain the identity or whereabouts of such Participants, after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments shall be forfeited after a reasonable time following the date any such payment first became due.

Any DCAP account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited.

Any amount allocated to an account shall be forfeited if it has not been used for reimbursement of Dependent care expenses by the 60th day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; to offset administrative expenses and future costs; and to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate and consistent with applicable regulations, as provided in the official plan documents for this Cafeteria Plan.

CLAIM AND APPEAL PROCEDURES

Your Health FSA Account and the DCAP Account come with a flex benefits debit card, which is pre-loaded with the value of your annual FSA or Daycare election amount and any FSA carryover amount. Simply swipe your Card at the time of purchase and the amount of your eligible expense will be automatically deducted from your account. Check with your daycare provider to make sure their Card approval apparatus is correctly coded as a "Daycare" provider. If you have question contact www.adminservices.optumhealthfinancial.com .

Each time you use the Flex Benefits Debit Card**,** you will receive a letter requesting documentation of the expense. To document the expense, send in a copy of the itemized cash register receipt, co-payment receipt, itemized statement from your provider, or prescription drug receipt. **The letter will be sent to your email address if available.** You will have 15 days to send in your documentation. It is best for participants to wait for the letter or email, attach a copy of the documentation to the letter or email copy and return it to Optum Bank.

- If Optum Bank does not receive documentation within 15-days of the first letter, a reminder letter will be sent. There will be a second 15-day grace period for claim documentation to be submitted from the date the reminder letter is sent (a total of 30 days). If we do not receive your claim documentation within **30-days** of the date the expense is incurred your Flex Benefits Debit Card will be temporarily deactivated until the outstanding expense(s) are substantiated. Once expenses are documented, your Flex Benefits Debit Card will be reactivated. I***f your purchases are from a retailer with an Inventory Information Approval System (IIAS), you will not receive a letter from Optum Bank requesting documentation. We still encourage members to keep their receipts as a record of their Flex purchases.***
- Many systems have Spam filters in place that will prevent our letters from reaching you. To avoid having your Flex Benefits Debit Card deactivated because you have not received the letters and have not documented your expenses, please add the following addresses to your Junk Mail or Spam to permit receipt of these requests.
  -customerservice@optumbank.com

Automatic Monthly Reimbursement for Orthodontia and Daycare Expenses

When you or your eligible dependent incurs an orthodontia expense, and you have established a payment plan with your orthodontist or contracted monthly payment plan with your Daycare Provider, you may receive a monthly reimbursement automatically, without filing a claim each month. To do this, you must submit an initial Flexible Benefit Claim Form along with your Orthodontia or Daycare Financial Agreement. You will not need to submit a claim form each month. ***You will be reimbursed only for the services incurred during the current month and within the current plan year.***

Reimbursement Claims Procedure

Claim Forms

You may obtain a Flexible Benefit Claim Form from your Human Resource Department, or you may print a form from OptumBank, Inc.'s web site: **www.adminservices.optumhealthfinancial.com**

Reimbursement Methods and Claims Processing Timelines

You have two options for payment, check by mail or direct deposit. The direct deposit method is recommended for a faster reimbursement. A Credit Authorization Form must be completed once at the beginning of your plan year for direct deposit. *All claims are generally processed within 10 working days of receipt of your claim. Reimbursements for claims are issued twice per week.*

a) *Timing*. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's eligible Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

b) *Claims Substantiation*. A Participant who has elected to receive benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator, in such form as the Plan Administrator may prescribe, no later than 60 days following the close of the Plan Year in which the Expense was incurred setting forth:

With respect to Health FSA claims:

(1) the person(s) on whose behalf the expenses have been incurred;

(2) the nature and date of the expenses so incurred;

(3) the amount of the requested reimbursement;

(4) a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

(5) other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

With respect to Dependent Care claims:

(1) the person(s) on whose behalf Dependent care expenses have been incurred;

(1) the nature and date of the expenses so incurred;

(3) the amount of the requested reimbursement;

(4) the name of the person, organization or entity to whom the expense was or is to be paid, the taxpayer identification number (Social Security number, if the recipient is a person);

(5) a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

(6) the Participant's certification that he has no reason to believe that the reimbursement requested, added to his other reimbursements to date for Dependent Care Expenses incurred during the same Plan Year, will exceed the applicable statutory limit for the Participant;

(7) other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request.

c) *Claims Denied*. If your claim is denied in whole or in part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of the medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(1) the specific reason(s) for the decision on review;

(2) the specific Plan provision(s) on which the decision is based;

(3) a statement of your right to review (upon request and at no charge) relevant documents and other information;

(4) if an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of chare to you upon request; and

(5) statement of your right to bring suite under ERISA Section 502(a) (where applicable).

d) *Claims Ordering*; *No Reprocessing*. All claims for reimbursement under the will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

Procedure if Benefits Are Denied Under This Plan.

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedures set forth above. The Executive Director of Human Resources and the Human Resources Manager acts on behalf of the Plan Administrator with respect to appeals.

Claims Procedures for Medical Insurance Benefits.

Claims and reimbursement for medical insurance benefits shall be administered in accordance with the claims procedures for the medical insurance benefits, as set forth in the plan documents and/or summary plan description for the medical insurance plan.