SOUTHSIDE CHRISTIAN SCHOOL OF THE UPSTATE
HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY
SOUTHSIDE CHRISTIAN SCHOOL OF THE UPSTATE
EFFECTIVE 1/1/2021

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SOUTHSIDE CHRISTIAN SCHOOL OF THE UPSTATE
Health Reimbursement Arrangement
Summary Plan Description

Your Employer (the "Employer") has established a plan known as a "Health Reimbursement Arrangement" (the "Plan"), with one or more underlying health reimbursement accounts ("HRAs") for its Employees to reimburse eligible Employees for Eligible Medical Expenses incurred by them, their Spouses and eligible Dependents. This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Attached to this SPD is an Adoption Agreement that describes information specific to your Plan. The Plan is intended to qualify as an Internal Revenue Code Section 105 medical reimbursement arrangement.

Part 1. General Information about the Health Reimbursement Plan

1.01 What is the purpose of the Plan?

The purpose of the Plan is to reimburse eligible employees for "Eligible Medical Expenses" that they or their Eligible Dependents incur during the Coverage Period set forth in the Adoption Agreement.

1.02 Who can participate in the Plan?

You may participate in the Plan if you meet the following requirements of an "Eligible Employee":

All Employees covered in the underlying medical plan.

Once you become a participant in the Plan, you enroll in one of the HRAs offered under the Plan. Each HRA will be categorized as "linked" or "non-linked" in the Adoption Agreement. A "Linked HRA" is paired (or linked) with a Group Health Plan. You cannot participate in a linked HRA unless you participate in the Group Health Plan.

For Linked HRAs, your enrollment period is the same as the enrollment period for the Group Health Plan. You may be automatically enrolled in a Linked HRA when you participate in the linked Group Health Plan. Your enrollment materials will state if you are automatically enrolled or if you need to submit an enrollment form.

The scope and level of reimbursement of Eligible Medical Expenses under the Plan varies by HRA. Each HRA offered under the Plan may impose additional eligibility requirements. These additional eligibility requirements will be described in Item 9 of the Adoption Agreement. Your participation in the Plan and the underlying HRA will begin on the date set forth in the Adoption Agreement.

Once you become a Participant, you may also receive reimbursements for Eligible Medical Expenses incurred by your "Eligible Dependents". Generally, "Eligible Dependents" means an employee's legal spouse (as defined by federal law), an employee's child (typically until the end of the year in which the child turns age 26, but could be sooner under a Linked HRA), and any other individual who is a tax dependent as defined under Code Section 105(b). An employee's child includes your son, daughter, stepchild, foster child, child placed with you for adoption, or legally adopted child, regardless of such child's tax dependent status, marital status, employment status, student status or residency. Additional requirements for dependent eligibility may be set forth in the Adoption Agreement for one or more of the HRAs offered under the Plan and such requirements may be more narrow (for instance, if it is a Linked HRA, only those dependents who meet the general requirements discussed above and are covered under the Group Health Plan may become covered under the HRA). See Item 9 of the Adoption Agreement for additional information).

If the Plan Administrator receives a qualified medical child support order relating to the Plan, the Plan will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your HRA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request

to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

1.03 When does coverage under the Plan end?

Your Participation in the Plan shall terminate on the earliest of:

(a) the date you cease to be an Employee;

(b) the date you cease to meet the eligibility requirements for an "Eligible Employee" as set forth in the Adoption Agreement;

(c) the date that you inform the Plan Administrator that you want to permanently opt out of and waive future reimbursements from this Plan; or

(d) the date this Plan is terminated or amended to exclude you or the class of employees of which you are a member.

You may be able to temporarily continue your coverage under the Plan if you lose coverage for certain reasons. See Part 2 and 3 for more information on continuation coverage.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

(a) the date your coverage ends;

(b) for your spouse, the date that you and your spouse divorce or legally separate (or receive an annulment);

(c) the date the individual ceases to meet the requirements of an Eligible Dependent as set forth in the Adoption Agreement; or

(d) the date the Plan is terminated or amended to exclude the individual or the class of dependents of which the individual is a member.

Your eligible dependents may also be entitled to temporarily continue coverage if coverage is lost for certain reasons. See Part 2 and 3 below for more information on continuation coverage.

In addition, your coverage under an HRA will end on the earlier of the date your participation in the Plan ceases or the date you cease to satisfy the eligibility requirements of the HRA.

1.04 What happens if I take a leave of absence?

If you are in a Linked HRA (as set forth in the Adoption Agreement), then your coverage under the HRA during a leave of absence is treated the same as it is under the Group Health Plan to which the HRA is linked, to the extent such treatment is consistent with the employer's applicable leave policies and applicable federal and/or state law.

1.05 How do I pay for coverage under the HRA that I receive during the Year?

You do not have to pay for your HRA coverage; HRA coverage is paid for solely by the Employer. However, if you lose coverage under the HRA and you are eligible to elect COBRA continuation coverage described in Part 2 below, you will have to pay the applicable premium for the continued coverage. See Part 2 below for more information on COBRA continuation coverage.

1.06 What amount of "Eligible Medical Expenses" may be reimbursed by the Plan each Year?

Each year you will be eligible to receive reimbursements equal to the maximum Annual Reimbursement Amount. The maximum Annual Reimbursement Amount that you may receive as reimbursement for Eligible Medical Expenses equals the sum of the employer's annual contribution ("Annual Employer Contribution") amount and the Carry Over amount, subject to any limitations and/or Cap set forth in the Adoption Agreement. The Annual Employer Contribution may be made periodically and the most that you can receive in reimbursement at one time will be your HRA balance at that time (subject to overall Cap), which is the sum of your accumulated employer contributions and the Carry Over amount. See Item 9 of your Adoption Agreement for more information.

1.07 What happens if I do not use the maximum Annual Reimbursement Amount made available during the Plan Year?

All or a portion of the annual contribution amount that you do not use for expenses incurred during the Coverage Period and submitted for reimbursement during the Plan Year before the end of the closing period may be carried over subject to limitations set forth in the Adoption Agreement for reimbursement of Eligible Medical Expenses incurred during subsequent years. You forfeit the remainder of your annual contribution amount that you are not permitted to carry over. Any unused amounts that are eligible to be carried over into a subsequent year and used for reimbursement of Eligible Medical Expenses are called "Carry Over Amounts."

A non-interest bearing Carry Over account will be set up to keep a record of the unused amounts that you are able to carry over each year pursuant to the terms of the Adoption Agreement. No actual account is established; it is merely a bookkeeping account and it is considered part of your overall HRA balance. Annual contribution amounts are used first to pay approved expenses and then Carry Over amounts are used to the extent necessary. Unused Carry Over amounts are carried over for reimbursement of Eligible Medical Expenses incurred during subsequent Plan Years.

1.08 What is an "Eligible Medical Expense"?

"Eligible Medical Expenses" are expenses incurred by you or your Eligible Dependents that satisfy the following conditions: a) the expenses are medical care expenses that would otherwise qualify for a deduction under Code § 213 (irrespective of the income threshold set forth in Code § 213); b) the expenses have not been or will not be reimbursed by any other source; c) the expenses must have been incurred during the Coverage Period set forth in the Adoption Agreement; and d) the expenses satisfy any additional conditions and/or limitations for an Eligible Medical Expense set forth in the Adoption Agreement.

Coverage of Eligible Medical Expenses may vary under each HRA option. The following expenses are not eligible for reimbursement under the Plan under any circumstance: i) Qualified Long Term Care Services; ii) health insurance premiums (including COBRA premiums) other than premiums for individual insurance policies that do not require health underwriting. Over the counter (OTC) drugs and medicines can only be reimbursed if a valid prescription relating to such OTC medicines and drugs has been obtained. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

In addition, you may not be reimbursed for any expenses arising before the Plan became effective, before you became a participant in the Plan, or for any expenses incurred after your participation in the Plan terminates except to the extent provided in Part 2 and 0 below.

1.09 How do I receive Benefits (or reimbursements) under the Plan?

You will receive reimbursement forms to submit to the Plan Administrator (or Plan Service Provider designated by Employer). You must complete the reimbursement form and submit it with the necessary documentation described in the Adoption Agreement.

If Benefit Coordinators, Inc. receives a claims file from the carrier you will only need to submit forms if requested by Benefit Coordinators, Inc.

The Plan Administrator (or Plan Service Provider) will review the claim and supporting documentation and determine the amount, if any, that is payable under the HRA (See 1.11 below for your rights if a claim is denied). Your Plan Administrator will advise you how often the payments are processed. If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you or to the Provider (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement).

If your claim for Eligible Medical Expenses is less than the Minimum Reimbursement Amount set forth in the Adoption Agreement, reimbursement for such expenses will be suspended until your approved expenses exceed the Minimum Reimbursement Amount. In addition, if your reimbursement is limited to your HRA balance at that time, then the amount of Eligible Medical Expenses that exceeds your HRA balance will be suspended until such

time as the total outstanding Eligible Medical Expenses submitted for reimbursement is equal to or less than the HRA balance.

You will not be reimbursed for Eligible Medical Expenses if the reimbursement exceeds the Annual Reimbursement Amount (or the Cap) set in the Adoption Agreement. The Adoption Agreement will state how the excess amount that is not reimbursed will be handled.

1.10 How long do I have to submit claims for reimbursement?

If you are currently a participant (active Employee or COBRA participant), you must submit an expense incurred during a Coverage Period no later than the end of the Run-Out Period set forth in the Adoption Agreement following the end of that Coverage Period. If you are no longer a participant, you have until the end of the Claims Submission Run-Out Period set forth in the Adoption Agreement to submit claims for reimbursement. If a Claims Submission Run-Out Period has not been established in the Adoption Agreement, then you have until the end of the Run-Out Period to submit claims.

1.11 What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from the Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time before the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Service Provider must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim and, why the information is necessary;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- whether an internal rule or guideline was relied on in making the determination and a statement that you may request a copy of the guidelines or protocol; and
- a statement reminding you of your right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an Appeal.* If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of appeal, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial referenced in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal and where you should file your appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the allotted number of days set forth in the denial notice after receiving the first level appeal denial notice from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- After you have exhausted these internal appeals procedures, you are entitled to an external review procedure, or you could file suit in federal court. You cannot file suit in federal court until you have exhausted these appeals procedures. For more information on the external review procedure, contact Benefit Coordinators, Inc.
- Does my coverage under this Plan end when my employment terminates?

Yes. Your normal participation will cease at the end of the day that your employment with the Employer terminates. However, you and your covered family members may have the opportunity to continue to be covered under the Plan pursuant to the Continuation Coverage provisions described in Part 2 below.

In addition to COBRA continuation coverage, your Employer may elect to have a Spend-Down option for you to use your HRA amounts (or a portion thereof) for Eligible Expenses after your employment ends. The Spend-Down option is explained in 0 below, and the Adoption Agreement will indicate whether or not the Spend-Down option is offered.

Part 2. COBRA Continuation Coverage

2.01 What is "Continuation Coverage" and how does it work?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") in certain instances where coverage under the Plan would otherwise end. These rules apply to the Plan unless the Employer is a "small employer" as defined under applicable law. The Plan Administrator can tell you whether your Plan is subject to these rules.

2.02 When can I continue coverage?

If you are a participant in the Plan, then you have a right to choose continuation coverage under the Plan if you lose your coverage because of:

- Reduction in your hours of employment,
- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct), or
- You take a military leave of absence that lasts 31 days or longer (in accordance with USERRA).

If you are the covered Spouse of a participant, then you have the right to choose continuation coverage for yourself if you lose coverage under the Plan for any of the following reasons:

- Death of your Spouse,
- Voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment,
- Divorce or legal separation from your Spouse,

- Your spouse goes on military leave of absence that lasts 31 days or longer (in accordance with USERRA), or
- Your Spouse becomes entitled to Medicare.

In the case of a covered Dependent child, the Dependent child has the right to choose continuation coverage if coverage under the Plan is lost for any of the following reasons:

- Death of the employee,
- Voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment,
- Divorce or legal separation of child's parents,
- Employee becomes entitled to Medicare (only in limited situations as described below),
- Employee goes on military leave of absence that lasts 31 days or longer (as required under USERRA), or
- Child ceases to be an eligible Dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage. Each person who is entitled to continuation coverage is called a "Qualified Beneficiary."

You or your covered dependents (including your spouse) must notify the COBRA Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. YOUR WRITTEN NOTICE SHOULD IDENTIFY THE QUALIFYING EVENT, THE DATE ON WHICH THE EVENT OCCURRED AND THE QUALIFIED BENEFICIARIES IMPACTED BY THE QUALIFYING EVENT. For other events you will be notified of your right to elect COBRA. When the COBRA Administrator identified in the Adoption Agreement is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

The COBRA Participant and/or covered dependent are responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

2.03 What type of coverage can be continued?

If you choose continuation coverage, you are entitled to the level of coverage in effect under your HRA immediately preceding the qualifying event. If coverage is modified for similarly situated active employees, then it will be modified for you. You will be eligible to make a change in your coverage upon the occurrence of any event that permits a similarly situated active employee to make a benefit change during a Plan Year. Each year that COBRA continuation coverage is in effect, you are entitled to the same amount of Annual Employer Contribution provided to similarly situated active employees plus any applicable Carry Over amounts from the previous year.

If you do not choose continuation coverage, your participation in the Plan will end on the date coverage ends in accordance with the qualifying event.

2.04 What should I do if I have a change in my status?

You (or your covered spouse and/or dependent children) must notify the Plan Administrator of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify the affected Qualified Beneficiary that he or she has a right to choose continuation coverage. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse.

An employee, covered spouse, or covered Dependent child is responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan or Medicare.

2.05 How and when do I elect COBRA continuation coverage?

You, your covered Spouse, and covered Dependent child(ren) are each entitled to make a separate election for continuation coverage under the Plan. If this is a Linked HRA as identified in the Adoption Agreement, you must elect to continue coverage under the Group Health Plan to which the HRA is linked in order to continue coverage under the HRA. If you are in a non-Linked HRA, you may elect the HRA and/or any other group health plans sponsored by your employer in which you participate, to the extent subject to COBRA. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator *(or COBRA Administrator)*. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the *COBRA Administrator* identified in the Adoption Agreement that you wish to continue coverage. You must notify the COBRA Administrator by using any of the methods identified in the COBRA notice provided by the Plan Administrator (or COBRA Administrator) as acceptable methods. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect COBRA continuation coverage.

2.06 How much will COBRA continuation coverage cost?

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the "applicable premium" for the period of continuation coverage. However, if you extend coverage due to a disability (see 2.08 below), you may have to pay 150% of the applicable premium. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date (which is typically the first day of the month). Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. If you pay a premium that is insufficient by an insignificant amount (the lesser of $50 or 10% of the premium), you will be given additional time to pay the remainder of the premium. Claims incurred during any period will not be paid until your premium payment is received for that period. If your timely elect continuation coverage and pay the applicable premium, continuation coverage will relate back to the first day on which you would have lost regular coverage.

2.07 How long can I continue the coverage?

The maximum period that you may continue coverage depends on the type of Qualifying Event that has caused you to lose coverage. If your spouse and/or dependent child lose coverage as a result of a qualifying event other than your termination of employment or reduction in hours of employment, your spouse and dependent child may elect COBRA continuation coverage for 36 months beginning on the date of the Qualifying Event. If you, your spouse, and your dependent children lose coverage as a result of your termination of employment or reduction in hours of employment (including a military leave of absence that is expected to last 31 days or longer), COBRA continuation coverage will continue for 18 months beginning on the date of your qualifying event. If either you, your spouse, or your dependent child was disabled (as determined by the Social Security Administration under Title II or Title XVI of the Social Security Act) at the time of or within 60 days of the Qualifying Event, then the 18-month continuation coverage period for each *qualified beneficiary* may be extended by 11 months to 29 months. To preserve your right to additional coverage by reason of disability, you must inform the *COBRA Administrator identified in the Adoption Agreement* of the determination of disability *prior to the end of the 18-month COBRA period of the 60-day notice period, whichever ends first. The 60-day notice period ends 60 days after the later of a) the date of the determination, b) the date of the qualifying event or c) the date coverage is lost as a result of the qualifying event. You must notify the COBRA Administrator within 30 days of a determination by the Social Security Administration that you are no longer disabled.* Additional Qualifying Events may occur while the 18-month (or 29 month) continuation coverage period is in effect that will allow your covered spouse and/or dependent children to continue coverage for 36 months from the original Qualifying Event. These include your divorce or legal separation from your spouse, your death, your becoming entitled to Medicare, or your dependent child ceasing to be a dependent child. The qualified beneficiaries must notify the COBRA Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. YOUR WRITTEN NOTICE SHOULD IDENTIFY THE QUALIFYING EVENT, THE DATE ON WHICH THE EVENT OCCURRED AND THE QUALIFIED BENEFICIARIES IMPACTED BY THE QUALIFYING EVENT. In addition, if you become entitled to Medicare and then you lose coverage as a result of a termination of employment or reduction in hours of employment within 18 months of becoming entitled to Medicare, your spouse and dependent children are entitled to 36 months of continuation coverage beginning on the date that you became entitled to Medicare.

However, continuation coverage may end earlier in the following circumstances:

- the last day of the month for which the last premium for your continuation coverage was timely paid;
- the date, after you elect continuation coverage, that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion or limitation (this does not apply to those continuing coverage as a result of a military leave of absence);
- *the first day of the month that begins more than 30 days after you have been determined by the Social Security Administration to no longer be disabled;*
- the date, after you elect continuation coverage, that you first become entitled to Medicare (this does not apply to those continuing coverage as a result of a military leave of absence); or
- the date employer no longer provides group health coverage to any of its employees

For those taking a qualified military leave of absence, coverage will be continued in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). For example, coverage may be continued on the same terms and conditions for up to 24 months (or the date that you were required to return to work in accordance with USERRA).

The COBRA Administrator is:

Isolved Benefit Services
PO Box 949 Coldwater, MI 49036

Part 3. Left Blank For Future Use

Part 4. Other Important Information

4.01 Unclaimed Reimbursement Payments

Any reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the eligible expenses were incurred shall be forfeited.

4.02 Plan Administrator

The Plan Administrator's name, address and telephone number appear in the Adoption Agreement to this Summary. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret the terms of the Plan, including possible ambiguities, inconsistencies, or omissions in the Plan and the Summary Plan Description issued in connection with the Plan. The Plan Administrator may designate certain claims processing (including the initial determination as to whether a claim is payable) and day-to-day administrative responsibilities to a Plan Service Provider identified in the Adoption Agreement. Nevertheless, the Plan Administrator reserves final discretionary authority for all matters arising under the Plan.

4.03 Type of Funding

The Plan is funded solely by your Employer (except during a period of COBRA continuation coverage described above). Benefits are paid as set forth in the Adoption Agreement.

However, your Employer may establish one or more trusts (e.g. a voluntary employee beneficiary association (VEBA) trust) to fund benefits provided under this Plan.

4.04 Plan Year

The date of the end of the year for purposes of maintaining the fiscal records of each of the plans is set forth in the Adoption Agreement to this Summary.

4.05 Identifying Your Employer

The official name, business address, telephone number, and employer identification number (EIN) of the Plan sponsor appear in the Adoption Agreement to this Summary. The names of any other employers who have adopted the Plan are set forth in the Adoption Agreement.

4.06 Official Plan Name and Plan Number

The official name of the Plan, and the number assigned to it for identification purposes, appear in the Adoption Agreement attached to this Summary.

4.07 Agent for Service of Legal Process

Legal process may be served on the Plan Administrator.

4.08 Employment

Participation in the Plan does not give any participant the right to be retained in the employ of his or her employer or any other right not specified in those plans.

4.09 Effective Date of the Plan

The effective date of the Plan is set forth in the Adoption Agreement.

4.10 Coordination of Benefits

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). However, certain coverages (e.g., Medicare for Participants who are active employees and their Dependents, and TRICARE benefits as required by law) will pay benefits only after this Plan to the extent required by applicable law. In addition, the Adoption Agreement may require that expenses that are otherwise covered under this Plan and under an employee funded Health FSA maintained by the Employer must be paid first by the Health FSA to the extent of any available funds in the Health FSA.

ERISA Rights

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

Receive Information about Your Plan and Benefits

You are entitled to:

- 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 insurance contracts, collective bargaining agreements and, if applicable, 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.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and, if applicable, copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if applicable). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You can continue health coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the plan because 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.

(This section applies only if the Plan is subject to HIPAA) Exclusionary periods of coverage for preexisting conditions under your group health plan may be reduced or eliminated if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when

you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit under the Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. 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 Plan Administrator. If you have a claim for benefits that 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 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.

What to do if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits and Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 and Security Administration.

PART 5. Visa® Debit Card

The Electronic Payment Card allows you to pay for Eligible Expenses as defined by the Plan(s) in which you participate at the time that you incur the expense. Here is how the Electronic Payment Card works, if indicated as an option under the Plan in Part 9 below.

(a) *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage (it can not be used at all MasterCard® acceptance locations and has no cash access), the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you when your card is provided to you. The card will be effective the first day of each Plan Year unless you do not affirmatively opt-out of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify, during the applicable Election Period, that the amounts in your Plan will only be used for Eligible Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) R*eimbursement under the card is limited to specific providers.* Use of the card for Eligible Medical Expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. In addition, the Card will be administered in accordance with applicable IRS guidance. Use of the card for other Plan expenses may be limited to merchants of qualified classifications. The card can not be used at all MasterCard® acceptance locations.

(e) *You swipe the card at the provider like you do any other credit or debit card.* When you incur an Eligible Expense at a qualified merchant, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Plan is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third-party statement from the provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over the counter item other than a drug or medicine (e.g., bandages), the written statement must indicate the name of the item.
- The date the expense was incurred.
- The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third-party statement may be required to be submitted. You will receive written notice from the Plan Service Provider that a third-party statement is needed in order to substantiate the expense. If requested by the Plan Service Provider, you must provide the third-party statement within 21 days (or other period specified in the notice) of the request.

(g) *There are situations where the third-party statement will not be required to be provided to the Plan Service Provider.* There are many situations in which you will not be required to provide the written statement to the Plan Service Provider. Situations in which you may not be required to submit the third-party statement are detailed in the Cardholder Agreement.

Note: You must obtain the third party receipt for ALL card transactions when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Plan Service Provider or the IRS requests it.

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Plan Service Provider, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is determined by the Plan Administrator. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Plan. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement), or the remaining unpaid amount will be included in your gross income as taxable “wages”.

(i) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above in 1.09. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

IMPORTANT: Over the counter (OTC) drugs and medicines can only be reimbursed if a valid prescription relating to such OTC medicines and drugs has been obtained. In order to ensure compliance with this requirement, you have two options:

i) For participants using health debit cards at a SIGIS participating pharmacist, you must present your prescription to the pharmacist at the time and point of sale. The pharmacist will process the transaction using your health debit card.
ii) For participants filing paper claims and/or purchasing drugs at a non-SIGIS participating pharmacy, you must submit a pharmacy receipt with an RX number or a copy of the written prescription with your request for reimbursement.

If the above requirements are met, and the OTC medicine or drug is otherwise an eligible medical expense, the claim will be processed. Note: a prescription is not required for eligible OTC medical items other than medicines or drugs (e.g., bandages, contact lens solution, etc).

PART 6. Legal Notices

Newborns' and Mothers' Health Protection Act of 1996--Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the individual's attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications resulting from the mastectomy (including lymphedemas)

These mastectomy-related benefits are subject to deductibles and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under your health plan coverage option. Call your health plan for more information.

APPENDIX

Attachment 1: Adoption Agreement