

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Plan	<p>The Employer is pleased to provide eligible employees the opportunity to participate in the Health Reimbursement Arrangement Plan (the “Plan”). The Plan provides valuable benefits to Participants. Specifically, the Plan provides Participants with a Health Reimbursement Account, to which Employer credits are made, and from which the Participant can be reimbursed for certain medical expenses not covered by their medical insurance or other sources.</p>
Purpose of this Summary	<p>This Summary Plan Description reflects the Plan as of the effective date listed on the Plan Information Sheet. The Plan Information Sheet attached to this summary describes many important features of the Plan, and should be referred to when reading the body of the summary. The purpose of this summary is to describe for you:</p> <ul style="list-style-type: none">▪ the principle features of the Plan▪ how the Plan works▪ certain rights participants have under the Plan
Plan Documents Control	<p>Please keep in mind that this Summary Plan Description is only a summary of the principal features of the Plan. The exact terms and specific legal rules that govern the Plan are set forth in the complete Health Reimbursement Arrangement Plan, which consists of a Plan document and an Adoption Agreement executed by the Employer. If there is an inconsistency or discrepancy between any term or provision in this Summary Plan Description and any term or provision in the Plan document or Adoption Agreement, the term or provision in the Plan document or Adoption Agreement controls.</p>
Questions	<p>If you have any questions after reading this summary, contact the Plan Service Provider (contact information below) or the Plan Administrator listed on the Plan Information Sheet.</p>
Plan Service Provider (Contact Information other than for reimbursement requests)	<p>Manley Services P.O. Box 70168 Eugene, OR 97401-0110 Phone (800)422-7038 or in Eugene area (541)485-7488 FAX (800)575-1109 or in Eugene area (541)485-8759</p>
(Contact Information for reimbursement requests)	<p>Manley Services P.O. Box 2797 Portland, OR 97208-2797 Claims FAX (866) 446-6090</p>

SECTION 1. DEFINITIONS

This Summary Plan Description refers to certain terms that have the meanings assigned below:

Active Participant	A Participant who is an Eligible Employee and is eligible to receive additional credits to the individual's HRA Account.
Code	The Internal Revenue Code of 1986, as amended from time to time.
Coverage Period	The period of time designated in the Plan Information Sheet, which time period is used for measuring the maximum amount of reimbursement available to a Participant.
Covered Person	An individual whose Medical Expenses are entitled to be reimbursed from a Participant's Health Reimbursement Account. Covered Persons include a Participant and, to the extent provided in the Plan Information Sheet, the Participant's Spouse and/or Dependents.
Dependent	A Dependent of a Participant is any individual who meets the definition of "dependent" for income tax purposes under Section 152 of the Code, as modified by Section 105 of the Code. In general, a dependent is an individual who receives more than 50% of his or her support from the Participant during a tax year. This may include the Participant's children, grandchildren, stepchildren, parents, in-laws, or any other person (other than the Participant's spouse) whose principal place of abode is the home of the Participant and who is a member of the Participant's household. You should ask the Plan Service Provider or Plan Administrator if you are unsure who qualifies as your Dependent.
Eligible Employee	An Employee who is eligible to participate in this Plan under the eligibility rules set forth in Section 2. of this Summary Plan Description and the Plan Information Sheet.
Employer	The entity or entities identified on the Plan Information Sheet who have adopted the Plan.
Entry Date	The date(s) described in the Plan Information Sheet on which an Eligible Employee can become an Active Participant in the Plan.
Employee	An individual who is treated as a common law employee of the Employer on the Employer's payroll records. If an individual is not treated as a common law employee of the Employer on the Employer's payroll records, the individual is not an Employee, even if the individual is later determined to have been a common law employee of the Employer.
Health Insurance Plan	The plan(s) that the Employer maintains for its Employees (and their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies or self-funded plan.

Inactive Participant	A Participant who is no longer an Eligible Employee and is not eligible to receive additional credits to the individual's Health Reimbursement Account, but still has a balance remaining in such account and continues to participate by being able to submit claims for reimbursement.
Medical Expense	An expense incurred by a Covered Person for "medical care" (as defined in Code Section 213(d) and excludable from income by Code Section 105(b) and applicable rulings and Treasury regulations), that is identified as reimbursable by the Plan. See Section 4. of this Summary Plan Description and the Plan Information Sheet for a description of expenses that qualify as Medical Expenses reimbursable by the Plan.
Participant	An Employee, former Employee or other beneficiary who is receiving benefits under the Plan. A Participant is either an Active Participant or an Inactive Participant.
Runout Period	<p>The period of time following the end of a Coverage Period during which a Participant may submit claims for reimbursement of Medical Expenses incurred during the Coverage Period.</p> <p>If the Plan does not allow for a carryover of expenses (discussed in Section 3 below), the Runout Period is the 90-day period following the end of the Plan Year in which the expense was incurred, except that for explanations of benefits issued by a health insurer more than 60 days but less than 270 days after the end of the Plan Year in which the expense was incurred, the Runout Period is 30 days from the date such explanation of benefits is issued.</p> <p>If the Plan allows for a carryover of expenses (discussed in Section 3 below), the Runout Period is the 90-day period following the end of the Plan Year in which active participation ceased, except that for explanations of benefits issued by a health insurance plan more than 60 days but less than 270 days after the end of the Plan Year in which active participation ceased, the Runout Period is 30 days from the date such explanation of benefits is issued.</p>
Spouse	A person who is legally married to a Participant for federal tax law purposes. An individual shall be deemed to be a Spouse of a Participant with respect to any expense which is reimbursable under the Plan if that individual is legally married to the Participant at the time the expense is incurred.
Threshold Amount	The amount of Medical Expenses that must be paid outside the Plan before reimbursement from the Plan is available. There may be Individual Threshold Amounts and Aggregate Threshold Amounts. If there are Individual Threshold Amounts and Aggregate Threshold Amounts, then Medical Expenses incurred by each Covered Person are reimbursable under the Plan only after he or she pays his or her Individual Threshold Amount outside the Plan, and Medical Expenses incurred by members of a family unit of Covered Persons (e.g., the Participant and Spouse, Participant and Dependents or Participant and family) are reimbursable under the Plan only after such Covered Persons, as a unit, pay the

applicable Aggregate Threshold Amount outside the Plan, even if each member of such unit has not satisfied his or her Individual Threshold Amount. The Threshold Amount(s), if any, need not be the same for every class of Participants. The Plan Information Sheet specifies any applicable Threshold Amount(s).

You, your

The Employee, former Employee or other beneficiary who is a Participant in the Plan.

SECTION 2.

SECTION 3. ELIGIBILITY AND PARTICIPATION

Eligibility

Employees of the Employer are eligible to participate in the Plan IF they:

- are employed on a regular basis, AND
- have satisfied the eligibility requirements outlined in the Plan Information Sheet.

The Plan only covers individuals classified by the Employer as common law employees. For example, individuals treated as leased employees, consultants, or independent contractors are not eligible.

Active Participation

Employees who have satisfied the eligibility requirements will enter the Plan and begin participating on the Entry Date coincident with or next following the date the eligibility requirements are satisfied. The Entry Dates are set forth on the Plan Information Sheet.

Cessation of Participation

A Participant ceases to be an Active Participant on the earlier of (1) the date the Participant ceases to be an Eligible Employee for any reason (provided active participation may continue beyond such date if COBRA coverage is available, elected and timely paid for), and (2) the date the Plan is terminated.

Special Rules

The Plan Information Sheet describes eligibility and participation rules for certain special situations, such as re-hires of former Participants.

SECTION 4. BENEFITS AND FUNDING

Benefits

During each Coverage Period, the Plan will reimburse Participants for Medical Expenses incurred by Covered Persons, up to the balance in the Participant's Health Reimbursement Account. In no event will a Participant be entitled to reimbursement in amounts greater than the balance of the Participant's Health Reimbursement Account (i.e., the account can never fall below \$0).

Annual Credit Maximum

For each Coverage Period, the Employer credits amounts to the Health Reimbursement Account of Active Participants. The maximum amounts that may be credited to those who are Active Participants for a full Plan

Year (the “Annual Credit Maximum”) are described in the Plan Information Sheet. Different amounts may be credited for different classes of Active Participants. Health Reimbursement Accounts may be subject to a maximum balance above which credits will not be made, and there may be different maximums for different classes of Active Participants.

Credits to Account

The amounts to be credited, the dates on which amounts are credited (each a “Credit Date”), and the period for which the credit is made (each a “Credit Period”), are described on the Plan Information Sheet. For example, if amounts are credited each quarter, then the Credit Period is the quarter, and $\frac{1}{4}$ of the Annual Credit Maximum will be credited to the accounts of Active Participants on the first day of each quarter. If designated on the Plan Information Sheet, those who begin participating in the middle of a Credit Period will have their credit for that Credit Period pro-rated (i.e., reduced). The Plan Information Sheet also tells you whether amounts credited to your Health Reimbursement Account for a Credit Period are temporarily credited or not temporarily credited when made. If amounts are not temporarily credited, then amounts credited to your Health Reimbursement Account for that Credit Period are not reduced solely because you cease being an Active Participant before the end of that Credit Period. If amounts are temporarily credited, then amounts are initially only temporarily credited on the Credit Date, with actual credits occurring on a daily basis throughout the Credit Period. Accordingly, if you cease to be an Active Participant in the middle of a Credit Period, the amounts not yet actually credited for the Credit Period shall be deemed not credited, and your Health Reimbursement Account will be correspondingly reduced (but not below zero).

Debits From Account

A Participant’s Health Reimbursement Account will be debited for reimbursements paid from the account. A Participant’s Health Reimbursement Account will also be charged a share of plan expenses not paid by the Employer. In no event will amounts in a Health Reimbursement Account be paid or made available to a Participant or beneficiary for any purpose other than payment or reimbursement of Medical Expenses.

Covered Persons

Amounts in a Participant’s Health Reimbursement Account are only available to reimburse Medical Expenses incurred by Covered Persons. The Plan Information Sheet will tell you whether your Spouse or Dependents can qualify as Covered Persons.

Carryover of Account Balance

The Plan Information Sheet indicates whether a carryover of account balance is allowed. If a carryover of account balance is allowed, unused amounts in an Active Participant’s Health Reimbursement Account do not “zero out” at the end of each year, but instead accumulate and remain available to reimburse Medical Expenses incurred in later years. The amount allowed to carry over may be subject to maximum dollar or percent limitations which could prevent a carryover of all unused amounts.

If a carryover of account balance is not allowed, unused amounts in a Health Reimbursement Account at the end of a Coverage Period are forfeited, and are not available for reimbursement of Medical Expenses

incurred in other Coverage Periods. See the Plan Information Sheet for details on the carryover of account balance, if any, available under the Plan.

Spend Down

The Plan Information Sheet indicates whether a spend down is allowed. There may be a spend down for the period following one, both or neither of the following “termination events”: termination of active participation while still employed by the Employer (e.g., due to reduction of hours below the minimum required for active participation or transfer to a non-benefited position), and/or severance of employment.

If a spend down is allowed following a termination event described above, some or all amounts in a Participant’s Health Reimbursement Account remain available to reimburse Medical Expenses incurred after the applicable termination event. A spend down may be subject to maximum dollar, percent, time period and/or vesting schedule limitations which could limit the time or amount available to spend down the account. In addition, the Medical Expenses reimbursable under the Plan may be expanded or contracted during the spend down period. See the Plan Information Sheet for details on the spend down, if any, available under the Plan.

If a spend down is not allowed, a Participant’s Health Reimbursement Account is not available to reimburse Medical Expenses incurred after a termination event described above. However, the Health Reimbursement Account remains available through the Runout Period to reimburse Medical Expenses incurred before the termination event.

Carryover of Expenses

The Plan Information Sheet indicates whether a carryover of expenses is allowed. If a carryover of expenses is allowed, then a Medical Expense incurred during a Coverage Period may be reimbursed from amounts credited to your Health Reimbursement Account in a later Coverage Period, but only if you were an Active Participant in both Coverage Periods, the expense qualified as a Medical Expense in both Coverage Periods, and the expense is timely submitted for reimbursement within the applicable Runout Period. In addition, the Plan Administrator may adopt rules to implement the carryover of expenses. See the Plan Information Sheet for any such rules.

Example of Carryover of Expenses: Suppose the Plan Year is the calendar year, you incur a Medical Expense in 2009, you terminate employment in 2011, the Plan allows a carryover of expenses, and the Plan Administrator has not adopted any special rules to implement the carryover of expenses. In that case, you may receive reimbursement of the 2009 Medical Expense by submitting it for reimbursement by the end of the Runout Period (i.e., 90 days after the end of the 2011 Plan Year).

If a carryover of expenses is not allowed, then a Medical Expense incurred during a Coverage Period may not be reimbursed from amounts credited to your Health Reimbursement Account in a later Coverage Period. Furthermore, you must submit the expense for reimbursement by

the end of the Runout Period for the Plan Year in which the expense was incurred.

Funding

All benefits under the Plan are paid from contributions by the Employer. Participants may not make any contributions toward Plan benefits, through salary reduction contributions or otherwise.

SECTION 5. MEDICAL EXPENSES

Medical Expenses

The Plan Information Sheet describes the types of Medical Expenses reimbursable under the Plan and/or types of expenses excluded from qualifying as Medical Expenses. In order to even potentially qualify as a Medical Expense, an expense must be for “medical care” as defined in Code Section 213(d) and excludable from income by Code Section 105(b) and the applicable rulings and IRS regulations. That generally includes amounts you must pay out of pocket for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, or for transportation for and essential to, or insurance covering, any of the foregoing, as those terms are used in Code Section 213(d). No expenses that may not be excluded from income under Code Section 105 or reimbursed by Health Reimbursement Arrangements under applicable IRS rules are reimbursable under the Plan. If you have questions about whether an expense is a Medical Expense reimbursable under the Plan, contact the Plan Service Provider or Plan Administrator.

Threshold Amounts

If an Individual Threshold Amount is designated in the Plan Information Sheet, then Medical Expenses incurred by each Covered Person are reimbursable under this Plan only after the Covered Person pays his or her Individual Threshold Amount outside this Plan. For example, if this Plan has a \$400 Individual Threshold Amount, then this Plan will not reimburse Medical Expenses until the Participant pays has paid \$400 of Medical Expenses outside this Plan. If Aggregate Threshold Amounts are designated in the Plan Information Sheet, then Medical Expenses incurred by members of a family unit of Covered Persons (e.g., the Participant and Spouse, Participant and Dependents or Participant and family) are reimbursable under this Plan only after such Covered Persons, as a unit, pay the applicable Aggregate Threshold Amount outside this Plan, even if each member of the unit has not satisfied his or her Individual Threshold Amount.

Cafeteria Plan Coordination

If the Employer also sponsors a cafeteria plan under Code Section 125, then the following rules apply:

- If any Medical Expense could be reimbursed under either the Plan or a “flexible spending account” available under the cafeteria plan, the Plan Information Sheet tells you which plan will pay first and which plan is not available until all funds available from the other plan have been exhausted.

- If the cafeteria plan allows for the payment of any group health insurance premium, then group health insurance premiums will not be an allowable Medical Expense under the Plan, regardless of anything to the contrary in the Plan Information Sheet or other provisions of the Summary Plan Description.

HSA Coordination

It is possible for participation in a health reimbursement arrangement to disqualify an individual from participating in a health savings account as defined in Code Section 223. If indicated on the Plan Information Sheet, benefits under the Plan will be limited so that participation in the Plan does not disqualify a Participant from participating in a health savings account. The Plan Information Sheet describes whether benefits are limited, what the limitations are, and which Participants are subject to the limitations.

SECTION 6. CLAIMS PROCEDURE

Reimbursement Requests

Paper Forms: To receive reimbursement for an eligible expense using a paper form, you must use a reimbursement request form provided by the Plan Administrator or its delegate, the Plan Service Provider. You must submit a completed reimbursement request form to the Plan Service Provider at the appropriate address listed on page 1 of this Summary Plan Description, along with proof of the expense, such as a bill or receipt from the service provider or other applicable independent third party which shows that the expense has been incurred and the amount and nature of the expense. You must verify, on the reimbursement request form, that the expense is not otherwise covered or reimbursable through any other plan or arrangement. If you are filing a claim for expenses that would be covered by insurance but for the insurance plan's deductible, co-payment, coinsurance or other similar feature, you may be required to submit the insurance company's explanation of benefits ("EOB") along with the reimbursement request form. You may file along with the information required above written comments, documents, records and other information related to your claim.

You can submit a completed reimbursement request form and required documentation at any time. However, requests for reimbursement *must be submitted by the end of the Runout Period* following the end of the Coverage Period in which the expense was incurred. Any request for reimbursement submitted after that deadline will be denied. An expense is incurred for these purposes on the date the medical care is provided, not the date the bill is sent, paid or received, the date the EOB is provided, or any other date. A request for reimbursement is considered submitted on the date the Plan Service Provider receives the completed reimbursement request form and supporting documentation.

Debit/Credit Card: If indicated on the Plan Information Sheet, you may be able to use a debit or credit card (a "health care card") issued by the Plan for reimbursement of Medical Expenses. If so, the health care card can be used to access your Health Reimbursement Account by swiping the card at the point of purchase of authorized merchants. You must keep all receipts for your records in case you are ever audited or you are required

to send in documentation to substantiate the service that was reimbursed. You will be sent a notice by the Plan Administrator requesting documentation on items that need to be substantiated. You will need to respond to these notices to avoid a temporary deactivation of the card. If your card is deactivated, it will be reactivated as soon as the appropriate account adjustment is made. You must agree to abide by the terms and conditions of a cardholder agreement and certify proper use of the card. Your card will be closed at severance of employment. See the Plan Information Sheet for further information regarding rules related to the health care card.

Improper Reimbursements. If you receive reimbursement (under either the Paper Form or Debit/Credit Card), and it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to the Plan. If you do not refund the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have income tax consequences for you.

Decision on Claim

Within a reasonable period of not more than 30 days after receiving your claim, the Plan Administrator will (a) decide whether to grant or wholly or partially deny the claim and (b) notify you in writing of the decision on the claim or pay the claim. However, the Plan Administrator may take up to an additional 15 days to review your claim and notify you if necessary for reasons beyond the Plan Administrator's control. You will be given written notice of the need for additional time before the end of the 30-day period.

Any notice of extension will specifically explain the standards on which entitlement to the claimed benefit is based, the unresolved issues that prevent the Plan Administrator from deciding the claim, and the additional information the Plan Administrator needs to resolve those issues.

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 Administrator must make a decision will be suspended from the date the Plan Administrator sends the notice of extension to the date you respond to the request for additional information.

Notice Denying Claim

Any written notice denying a claim will: (i) state the specific reason or reasons for the denial, (ii) refer to the specific Plan provisions on which the denial is based, (iii) describe any additional material or information needed for you to perfect the claim and explain why it is needed, (iv) state any internal rule, guideline, protocol, or other similar criterion the Plan Administrator relied on in denying the claim, (v) describe the Plan's review procedures and the time limits that apply to those procedures, and (vi) state that the claimant has a right to bring a civil action under ERISA

Section 502(a) to contest the denial of the claim after any denial of the claim on review.

Deemed Denial of Claim

A claim is deemed denied if by the date the Plan Administrator is required to provide you with any written notice denying the claim the Plan Administrator does not provide you with written notice wholly accepting the claim.

Filing For Review

If you disagree with the Plan Administrator's decision, you may file an appeal. Any claim for benefits under the Plan that is denied or deemed to be denied by the Plan Administrator will be reviewed if within 180 days after receiving the written notice denying the claim, or within 180 days after the date the claim is deemed to be denied, you or your personal representative (either person referred to below as the "claimant") file with the Plan Administrator a written request for review. A request for review may be filed in writing or by fax or email. The Plan Administrator will provide a request-for-review form upon request. A request-for-review is filed on the date the Plan Administrator receives the request either by mail, fax or email. A request-for-review is completed for this purpose if the request-for-review identifies the claimant and indicates that the claimant is requesting review of a claim. A claimant may file, with the request-for-review, written comments, documents, records, and other information relating to the claim, including any information identified as missing or needed in any notice denying the initial claim.

Review Procedures

No Deference. The review will not give deference to the initial decision on the claim and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who denied the claim nor a subordinate of such individual.

Conduct of Review: On the review:

(a) The claimant may submit additional written comments, documents, records, and other information relating to the claim;

(b) The claimant will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information that: (i) was relied on in deciding the claim; (ii) is a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, even if not relied on in deciding the claim; (iii) was submitted, considered, or generated in the course of deciding the claim, even if not relied in deciding the claim; or (iv) demonstrates compliance with safeguards (described below).

(c) The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, even if not submitted or considered in the initial decision on the claim.

Time Period For Review

Within a reasonable period of not more than 60 days after the Plan Administrator receives a request for review the Plan Administrator will notify the claimant in writing of the Plan's decision on the claim and no extension shall be available.

Notice Denying Claim	Any written decision on review wholly or partially denying a claim will: (i) state the specific reason or reasons for the denial, (ii) refer to the specific Plan provisions on which the denial is based, (iii) state that the claimant will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information described in section (b) of the section above titled "Conduct of Review," (iv) state any internal rule, guideline, protocol, or other similar criterion the reviewer relied on in denying the claim, (v) state that the claimant has a right to bring a civil action under ERISA Section 502(a) to contest the denial of the claim; and (vi) state "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
Deemed Denial of Claim	A claim is deemed denied on review if by the date the Plan Administrator is required to provide the claimant the Plan's written decision on the claim the Plan Administrator does not provide the claimant written notice wholly accepting the claim or fully pay the claim.
Hearing	In deciding a claim, including on review, the Plan Administrator and the reviewer may hold a hearing under such procedures as the Plan Administrator or the reviewer determines.
Safeguards	In deciding a claim, including on review, the Plan Administrator and the reviewer will verify that decisions on claims and on review are made in accordance with the documents governing the Plan and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants.
Exclusive Purpose	In deciding a claim, including on review, the Plan Administrator and the reviewer will act for the exclusive purpose of providing benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan.
Representative	A claimant's authorized representative may act on the claimant's behalf for purposes of these claims procedures.

SECTION 7. CHANGE IN RIGHTS UNDER THE PLAN

Right to amend or terminate the Plan	<p>The Employer may amend the terms of the Plan at any time. For example, but without limitation, the Employer could change the amounts to be credited to Health Reimbursement Accounts, the Credit Dates, any carryover or spend down features, the type of expenses reimbursable under the Plan, and any other Plan feature or benefit. Such amendment(s) would affect (and possibly eliminate) the contributions to and amounts available from the Health Reimbursement Accounts of some or all Participants.</p> <p>The Employer has adopted the Plan with the intention and expectation that it will be continued indefinitely, but the Employer has no obligation to</p>
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maintain the Plan and may amend or terminate the Plan or its participation in the Plan at any time.

Effect of Termination
of Employment

A termination of employment, reduction in hours or other event, as described in the Plan Information Sheet, that causes an Active Participant to cease to remain an Active Participant, will terminate the Active Participant's right to receive additional credits to his or her Health Reimbursement Account, as of the date specified in the Plan Information Sheet. Nevertheless, (i) the Participant may submit claims for expenses incurred prior to loss of active participation through the end of the Runout Period following the Plan Year in which active participation ceased; (ii) if a spend down is allowed (see Section 3 of this Summary Plan Description), expenses incurred after loss of active participation may be reimbursed; and (iii) the Participant may have a right to elect COBRA continuation coverage.

SECTION 8. NOTICES

COBRA Rights

An employee who ceases to be eligible to participate in the Plan because of a termination of employment or a reduction of hours has the right to continue participation pursuant to a law known as "COBRA." COBRA rights also apply to an employee's spouse and dependents, who may lose eligibility under the Plan for reasons such as a divorce, as an example. While COBRA allows continued participation in the Plan, it requires the employee (or the spouse or dependent, as the case may be) to pay for the coverage. Payment of the applicable "premium" would be with after-tax dollars. You will be provided additional information about your COBRA rights when you experience an event that would give rise to COBRA continuation coverage.

Mothers/Newborns

The Plan 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 caesarean 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, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA Notice

A group health plan, and a health insurance issuer providing health insurance coverage in connection with the group health plan, that provides medical and surgical benefits with respect to a mastectomy (including the Plan), shall provide, in a case of a Participant or beneficiary who is receiving benefits in connection with the mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for –

reconstruction of the breast on which the mastectomy has been performed,

surgery and reconstruction of the other breast to produce a symmetrical appearance, and

prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient. Such coverage is available under the Plan; provided, however, that such coverage is subject to all limitations and requirements established for other benefits under the Plan.

SECTION 9. STATEMENT OF ERISA RIGHTS

ERISA Rights

As a Participant in the Plan, you may be 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:

(A) Receive Information About Your Plan and Benefits:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, 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.

Receive a summary of the Plan's annual financial report. The law may require the Plan Administrator to furnish each Participant with a copy of this summary annual report.

(B) Continue Group Health Plan Coverage. Continue health care coverage for yourself, Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and 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.

(C) 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 you and other Plan Participants and

beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension welfare) benefit or exercising your rights under ERISA.

(D) Enforce Your Rights.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report 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 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.

(E) 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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit 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 Pension and Welfare Benefits Administration.

THE ABOVE IS INTENDED TO BE A SUMMARY OF THE PROVISIONS OF THE PLAN. IF YOU HAVE ANY SPECIFIC QUESTIONS REGARDING THE PLAN, YOU SHOULD REVIEW THE PLAN DOCUMENT WHICH IS AVAILABLE FROM THE PLAN ADMINISTRATOR. IN THE EVENT OF ANY INCONSISTENCY BETWEEN THIS SUMMARY AND THE PLAN, THE TERMS OF THE PLAN DOCUMENT WILL GOVERN.