WHAT IS A FLEXIBLE BENEFIT PLAN AND HOW DOES IT WORK FOR YOU?

Flexible Benefit Plans are an innovative way for you to save tax dollars - while receiving the best in fringe benefit plans. By participating in your company's Flexible Benefit Plan you can choose the benefits that you most need and want from a "menu" of benefits. Pay for your group healthcare premiums; certain healthcare expenses; and adult and child dependent care with UNTAXED dollars.

What is a Flexible Benefit Plan?

A Flexible Benefit Plan is a voluntary program that provides you with the ability to redirect a portion of your pre-tax salary, which will be "banked" in a tax-free account. This money is then used to pay for your insurance premiums and other expenses that you formerly paid for with after-tax dollars.

If I elect to redirect my compensation, how can this benefit me?

The biggest advantage is the tax savings. Since a Flexible Benefit Plan uses pre-tax dollars for reimbursement of qualifying expenses, you can reduce your income taxes and social security tax by reducing your taxable salary.

If I redirect part of my pay, won't I make less money?

No. Your net take home pay will increase because of your tax savings.

Why should I participate in the Medical Reimbursement Plan if I already have medical insurance?

The Medical Reimbursement Plan offers reimbursement of medical care expenses that are NOT reimbursed by your insurance. Some examples: deductibles; copays; eye exams; glasses & contact lenses; lasik surgery; prescribed medication and some over the counter healthcare items.

Can I change or revoke my elections during the plan year?

In general, no. However, there is an exception for a change in family status. This includes marriage; divorce; death of a spouse or childbirth or adoption of a child; termination or commencement of a spouse's employment and/or other events that the Administrator determines will permit a change or revocation of an election during the plan year.

What documentation do I need to provide the Flexible Benefit Plan Administrator to be reimbursed for expenses I incur?

Your company will provide you with a reimbursement request form. You will be required to attach a copy of the medical or dependent care billing to this form, then return it to the Administrator.

What if I don't use all the money I redirect?

You will be assisted in accurately determining your allowable expenses for the plan year so you can avoid having unused benefits at the end of the year. However, if you do have funds remaining in your account at the end of the year, that amount will be forfeited.

Are there any negatives I should know about?

Yes. Because you are not paying social security tax on that portion of your income that has been redirected, your social security benefits may be reduced.

SAMPLE CAFETERIA PLAN
Taxable Income Comparison

	Without Conversion Plan	With Conversion Plan
GROSS MONTHLY COMPENSATION	**$2,000.00**	**$2,000.00**
Less Pre-Tax Redirections		
– Medical Reimbursement Plan	$ 0.00	$ 150.00
– Dependent Care Plan	$ 0.00	$ 200.00
TAXABLE INCOME	**$2,000.00**	**$1,650.00**
Less Taxes and After Tax Reductions		
– Federal Income Tax (20%)	$ 400.00	$ 330.00
– State Income Tax (8%)	$ 160.00	$ 132.00
– Social Security/Medicare (7.65%)	$ 153.00	$ 126.00
– Medical Reimbursement Plan	$ 150.00	$ 0.00
– Dependent Care Plan	$ 200.00	$ 0.00
NET PAYCHECK	**$937.00**	**$1,062.00**

INCREASE IN DISPOSABLE INCOME

- ✓ Per Month **$ 125.00**
- ✓ Per Year **$ 1,500.00**
- ✓ As a Percentage of Pay **6.25%**

www.primarkbenefits.com

SYNOD OF THE PACIFIC FLEXIBLE BENEFIT PLAN
MEDICAL AND DEPENDENT CARE EXPENSE REIMBURSEMENT
COMPENSATION REDUCTION AGREEMENT

Name: _____

Email Address: _____

Mailing Address:_____City:_____State:_____ Zip:_____

Social Security Number: _____ Effective Date:_____

I elect to have the my compensation reduced by the following amount for Medical and Dependent Care Expenses:

Annual Reduction in Pay for Medical Expenses: $ _____
(maximum annual salary reduction $3000.00)
Annual Reduction in Pay for Dependent Care Expenses: $ _____
(maximum annual salary reduction $5000.00)

Please also choose a reimbursement method: Mailed check: ☐ -OR- Direct deposit (also **provide a voided check**): ☐

I understand that

- My compensation each pay period will be reduced by the total amount above divided by the number of pay periods in the year (or remaining in the year if you are becoming a participant at any time except at the beginning of the Plan Year).
- I cannot change or revoke this benefit election or Compensation Reduction Agreement as of any date prior to the next January 1st, unless I have a change in family status (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Administrator determines will permit a change or revocation of an election).
- Prior to Jan. 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected cash instead of salary reduction for the new Plan Year (Jan. 1st to Dec. 31). In addition, this Compensation Reduction Agreement will continue by its terms in the amount of the elected contribution.
- The Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the provisions of the Plan if it is believed to be advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.
- This benefit election will automatically be canceled as of the date of my termination of employment.

SIGNATURE:_____ DATE:_____

PRIMARK
BENEFITS

New OTC Rule Fact Sheet

For FSA Participants

Background

Recent legal changes have changed some of the rules that govern your Flexible Spending Account (FSA). Included in the new law was a rule that requires a doctor's prescription for the reimbursement of Over-the-Counter (OTC) drugs and medicines from an FSA.

When Does the Change Take Effect?

The law takes effect on January 1, 2011, which means that any OTC drug or medicine purchase made in 2011 will require a doctor's prescription before it can be reimbursed from your account.

What Does the Change Mean for Participants?

To put it simply, the new rule adds an extra step in the process. Prior to 2011, all that was required for reimbursement was a valid receipt submitted via fax or by mail. Now any accountholder seeking reimbursement will have to first go to a doctor for a prescription, which will then need to be submitted to Primark Benefits along with the receipt. It's important to remember that you will still be able to use your account for the same OTC drugs and medicines as before. You will just need a doctor's prescription before you can be reimbursed.

What Exactly Is a Prescription for an OTC Drug or Medicine?

A prescription for an OTC drug or medicine should be exactly the same as one for a drug or medicine that can only be obtained with a doctor's prescription. When you go to the doctor, simply ask him or her to write you a prescription for the item for which you want to be reimbursed. The prescription will need to comply with state prescription laws, but generally, if the prescription is written on a prescription pad, it should be sufficient.

Continued on next page

What Specific OTC Drugs and Medicines Will Require a Prescription and Which Will Not?

As a general rule, any OTC drug or medicine that you take orally or topically will require a prescription. What will not require a prescription are medical devices (such as monitors) and supplies (such as bandages and contact lens solution). Insulin and diabetic supplies are also items that will not require a prescription. For your convenience, we've created a summary list of common items that can and cannot be reimbursed without a doctor's prescription. When in doubt, obtain a prescription for quickest reimbursement.

FSA Eligible Medical Items That **Do NOT Require** a Doctor's Prescription	FSA Eligible Medical Items That **NOW Require** a Doctor's Prescription
Bandages and related items (over-the-counter)	Acne treatments
Birth control (over-the-counter)	Allergy & sinus medicine and products
Blood pressure monitors	Antacids
Cholesterol test kits and supplies	Antibiotic ointment
Condoms	Aspirin or other pain relievers
Contact lenses, cleaning solutions, etc.	Asthma medicines or treatments
Crutches, canes, walkers or like equipment (purchase or rental)	Canker & cold sore treatments
Dentures, bridges, etc.	Chest rubs
Diabetic monitors, test kits, strips and supplies	Cold & flu medicines
Eye related equipment/materials	Corn and callus removers
Eyeglasses (over-the-counter)	Cough drops & sore throat lozenges
Fertility monitors (over-the-counter)	Cough syrup
First aid kits (over-the-counter)	Diaper rash ointments and creams
Hearing aids and batteries	Ear drops & wax removal
Incontinence supplies	Gastrointestinal medications
Insulin, testing materials and supplies	Herbal or homeopathic medicines
Magnetic therapy (over-the-counter)	Laxatives
Medical equipment (for treatment of medical condition) & repairs	Lice treatments
Medical monitoring and testing devices	Motion & nausea medicines
Medical supplies (for treatment of a medical condition)	Over-the-counter products for dental, oral and teething pain
Monitors & test kits (over-the-counter)	Pain relievers
Occlusal guards to prevent teeth grinding	Propecia (for treatment of a medical condition)
Orthotics	Retin-A (for non-cosmetic purposes)
Orthopedic and surgical supports	Sleep aids
Over-the-counter bandages and related items	Toothache and teething pain relievers
Ovulation monitor (over-the-counter)	Wart removal treatments
Pregnancy tests (over-the-counter)	
Reading glasses (over the counter)	
Teeth grinding prevention devices	
Urological products	
Walking aids (canes, walkers, crutches and related supplies)	
Wheelchair and repairs	
Wound care (over-the-counter)	

QUALIFYING EXPENSES
Medical Care

Under the plan, you will be reimbursed only for those types of medical-expenses normally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation).

EXAMPLES OF REIMBURSABLE ITEMS INCLUDE:

- Medication, birth control pills, vaccinations or OTC drugs or medicines your doctor prescribed.
- Office visits to a medical doctor, dentist, optician/optometrist, chiropractor, osteopath, podiatrist, psychiatrist, psychologist, physical therapist, acupuncturist or psychoanalyst for medical reasons only.
- Medical examination, X-ray and laboratory service, or insulin treatment and whirlpool baths prescribed by a doctor.
- Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing assistance.
- Hospital care (including meals and lodging), clinic costs and lab fees.
- Medical treatment at a center for substance abuse.
- Medical aids such as: hearing aids (and batteries); false teeth; eyeglasses; contact lenses; braces; orthopedic shoes; crutches; wheelchairs; guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs associated with getting medical care.

YOU CANNOT OBTAIN REIMBURSEMENT FOR:

- The basic cost of Medicare insurance.
- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax.
- Nursing care for a healthy baby.
- Illegal operations or drugs.
- Travel your doctor told you to take for rest or change.
- Cosmetic surgery.

Please note: Qualifying medical expenses include only those expenses incurred for you, your spouse, and dependents you list on your Federal tax return. IRS Publication 502, Medical and Dental Expenses, lists medical expenses that can and cannot be deducted and, therefore, reimbursed under this plan.

MEDICAL FLEXIBLE SPENDING ACCOUNT

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form with the documentation attached to Primark Benefits.

Invoices Attached

Please list the invoices or statements that are attached. These documents must be invoices or other written statements from the third parties who provided the medical services and must show the names of the providers, the dates that services were provided, the amounts charged for the services, and a brief description of the services.

In general, the types of medical services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would allow for the medical and dental expense deduction under Internal Revenue Code Section 213. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you make deposits into your medical reimbursement account. For example, if you start deposits with the pay period that begins on February 1, you can submit a claim for a February 1 doctor's visit, but not for a doctor's visit on January 31, even though you don't receive a bill until February 15.

Total Amount Requested

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached.

At any time during the plan year, you may request reimbursement for expenses that may exceed the amount that you have deposited into your flexible medical account. However, your reimbursement cannot exceed the amount that you have committed to deposit for the Plan Year, minus any reimbursements you have already received for the Plan Year. Special rules apply if you terminate employment or otherwise end your participation in the Plan. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of the maximum reimbursement amount.

Statement by Participant and Signature

Besides providing the information that is needed to prove that your claim is for qualified for reimbursement, you must sign the form, thereby confirming that you have not and will not submit these expenses for reimbursement from another Plan. For example, if you are covered by more than one medical insurance policy or more than one medical flexible spending account, you cannot receive a reimbursement from this Plan and from the other Plan, too.

SYNOD OF THE PACIFIC

January 1, 2011 - December 31, 2011

MEDICAL CARE EXPENSE REIMBURSMENT FORM

Employee's Name: _____

Social Security Number: _____ Period Covered: _____

Address: _____ City_____ State_____ Zip Code_____

Date	Person Incurring Expenses	Relationship	Provider	Description	Amount

I request reimbursement for the attached expenses under the SYNOD OF THE PACIFIC. I certify that I or my eligible dependents have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 and 105 of the Internal Revenue Code.

Signature: _____ Fax To : PRIMARK BENEFITS 650-692-2260 or 875 Mahler Rd. Ste. 105, Burlingame, Ca 94010

Date: _____

QUALIFYING EXPENSES
Dependent Care

Under the plan you will be reimbursed only for dependent care expenses meeting all of the following conditions:

- The expenses are incurred for services rendered after the date an election form is completed and during the plan year to which it applies.
- Each individual for whom you incur each expense is:
  - a dependent under age 13 for whom you are entitled to claim as a dependent (or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce) on your federal income tax return; or
  - a spouse of other tax dependent (or a child you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce) who is physically or mentally incapable of caring for himself or herself.
- The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you (and your spouse, if you are married) to be gainfully employed.
- If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in (2) above, or who regularly spends at least eight hours per day in your household.
- 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 complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred
- The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

DEPENDENT CARE

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form, with the documentation, attached to Primark Benefits.

**** Invoices Attached ****

Please list the invoices or statements which are attached. These documents must be issued by the third parties who provided the dependent care and must show the name and tax identification number of the provider, the dates that services were provided, and the amounts charged for the services.

In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21(b)(2). Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you make deposits into your dependent care reimbursement account. And, you cannot ask the plan to reimburse you in advance. For example, if you start deposits with the pay period that begins on February 1, on February 2 you can submit a claim for child care given on February 1, but not for care given on January 31 or for care to be given in March.

**** Total Amount Requested ****

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached.

If your expenses qualify for reimbursement from the Plan, you will be reimbursed for the total of your expenses, but not more than your account balance in the Plan. Your account balance is the total of the deposits you've made into your Dependent Care Flexible Spending Account minus the reimbursements you've received for the Plan Year.

**** Statement by Participant and Signature ****

Besides providing the information that is needed to prove that your claim is qualified for reimbursement, you must sign the form, confirming that you have not and will not submit these expenses for reimbursement from another Plan. For example, if you are covered by more than one dependent care plan, you cannot receive a reimbursement from this Plan and from the other Plan, too.

SYNOD OF THE PACIFIC
DEPENDENT CARE EXPENSE REIMBURSMENT FORM

Employee's Name: _____

Social Security Number: _____ Period Covered: _____

Address: _____ City_____ State_____ Zip Code_____

Dependent Name	Relationship	Date of Birth	Dates of care (From/To)	Name and Address of Provider/Facility	Tax ID or Social security #

If day care is provided by one of your children, please give that child's age. _____

Amount of Reimbursement requested: $_____ (Attached receipts, cancelled checks or bills)

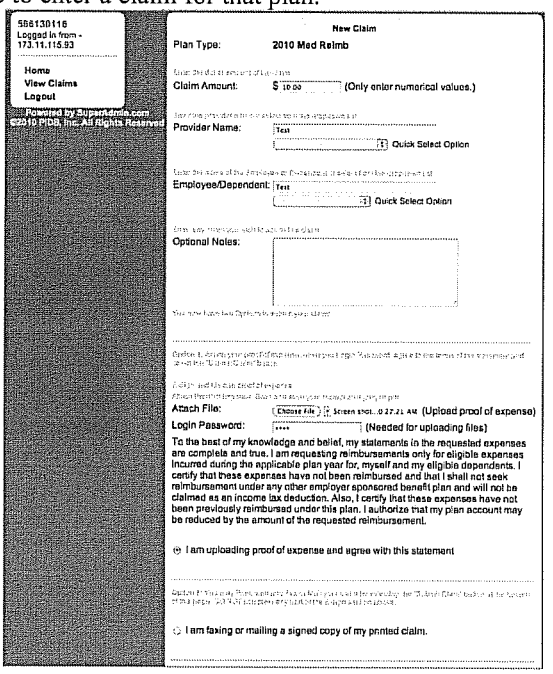
I request reimbursement for the attached expenses under my Dependent Care Expense Reimbursement Expense Account. I certify that these expenses are for dependent care as defined by the Internal Revenue Service. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be.

Signature:_____ FAX TO: PRIMARK BENEFITS or 875 Mahler Rd. Ste 105, Burlingame, Ca 94010
650-692-2260

Date:_____

Accessing the System:
Go to www.primarkbenefits.com.
Click on *Flex Plan Log In.*
Enter your username and password. Your user name is your social security number.
If this is your first time logging on, you should have received a 4-digit PIN from your plan administrator; this is your password.
If this is your first time logging on, you will be prompted to create a new password (or PIN) that only you will know.
Once you've logged in, you will see your home screen, showing the plans in which you are a participant.

Creating a Claim or Claims:
From the home screen, click *Create Claim.*
On the New Claim screen, click a plan name to enter a claim for that plan.



Complete all fields on the New Claim form.

Choose either *Option 1* (E-Sign & upload proof of expense) or *Option 2* (print claim form & fax or mail proof of expense)
Click *Submit Claim.*
The next screen will allow you to input additional expenses for this claim by asking you if you wish to add more expenses to your claim or finish the claim submission process.
The next page will prompt you to print out the completed claim. If you choose Option 1 print & keep a copy for your files. If you choose Option 2, print and sign the claim form and submit it to your plan administrator with the appropriate documentation (typically a receipt for the product or service). Click *Claim Form* to open and print the claim form.
Note: if your computer cannot view PDF documents, you may need to download the free Adobe Acrobat reader from www.adobe.com.

Viewing Claims:
To view your claims, click *Home* and then click *View Claims.*
To view details for a claim, click the plan name in the appropriate row.

Viewing Elections:
To view your election amounts, click *Home* and then click *View Elections.*
To change your election amount, contact your company's plan administrator or HR department.

If you have more questions, contact your plan administrator at:

Primark Benefits
875 Mahler Rd., Suite 105
Burlingame, CA 94010
Phone: (650) 692-2043
Fax: (650) 692-2260

SUMMARY PLAN DESCRIPTION

FOR THE

SYNOD OF THE PACIFIC

FLEXIBLE BENEFIT PLAN

TABLE OF CONTENTS

SUMMARY OF THE SYNOD OF THE PACIFIC FLEXIBLE BENEFIT PLAN

(1) What is the purpose of this Plan?

Under the reimbursement provisions of the Synod of the Pacific Flexible Benefit Plan (the "Plan"), you can convert certain medical and dependent care expenses from after-tax to pre-tax expenses. This is done through a salary reduction agreement under which you agree to have your compensation reduced by a specified amount each pay period. This amount is then available to reimburse you for covered expenses.

Under the Premium Conversion Plan, that portion of the premiums that you pay for benefits under any Medical and Dental Insurance Plans maintained by Synod of the Pacific (the "Employer") are paid on a pre-tax basis.

This summary describes the highlights of the Plan. It is not intended to be a complete description of the Plan, and in the event of any conflict between this summary and the Plan, the provisions of the Plan control your right to benefits. In addition, no provision of the Plan or this summary will give any employee any right to continued employment by the Employer or will in any way prohibit changes in the terms or conditions of employment of any employee covered by the Plan.

(2) What are the definitions of some of the terms used in this Plan?

The following definitions explain some of the important terms used in this summary:

- *Code* means the Internal Revenue Code of 1986, as amended.
- *Dental Insurance Plan* means a group Dental Insurance Plan under which employees are required to pay all or a portion of the premiums payable for the benefits provided under the plan.
- *Dependent Care Expense Reimbursement Plan* means the Dependent Care Expense Reimbursement Plan by which you can pay certain dependent care expenses from pre-tax income.
- *Enrollment Period* means the period during which you can enroll to participate in the various programs offered under the Plan. For the first Plan Year which begins on the adoption date of the Plan, the enrollment period for eligible employees begins when notice of the Plan is first provided to Employees and ends 60 days thereafter. For years after that, the Enrollment Period for eligible Employees is the 60-day period prior to the first day of the Plan Year.
- *Entry Date* means the first day of the month following the date you meet the eligibility requirements.
- *Highly Compensated Employee* means generally any Employee who is a 5% owner; or who had Compensation in excess of $80,000. The $80,000 figure is adjusted for inflation.
- *Key Employee* means certain owners and officers of the Employer.
- *Medical Care Expense Reimbursement Plan* means the Medical Care Expense Reimbursement Plan by which you can pay certain uninsured medical expenses from pre-tax income.
- *Medical Insurance Plan* means a group Medical Insurance Plan under which the employees are required to pay all or a portion of the premiums payable for benefits under the plan.

► *Participant* means any Employee who participates in the Plan.

► *Plan* means the Synod of the Pacific Flexible Benefit Plan as set forth herein, together with any and all amendments and supplements that may be made to the Plan from time to time.

► *Plan Year* means the January 1st to December 31st.

► *Premium Conversion Plan* means the portion of the Plan under which you can make your premium payments for company provided medical and dental insurance using pre-tax dollars.

► *Qualified Reimbursement Expense* means expenses which qualify under the Internal Revenue Code for reimbursement under this Plan, and which are not otherwise deducted on the Participant's income tax return or reimbursed by insurance.

(3) How can I participate in the Medical Care Expense Reimbursement Plan and Dependent Care Expense Reimbursement Plan?

If you are not a member of an ineligible class of Employees as described below, you will be eligible to enter the Medical Care Expense Reimbursement Plan and Dependent Care Expense Reimbursement Plan as a Participant on the Entry Date coinciding with or next following the date you complete 60 days of service. The Entry Date is the first day of the month following the date on which you satisfy the eligibility requirements.

Owner-employees, partners, and Employees who are considered as owning more than a 2% interest in the Employer in any year in which the Employer is an electing small business corporation are not eligible to participate in the Plan.

After you become a Participant, you must file a Compensation Reduction Agreement with the Plan Administrator before the beginning of each Plan Year in order to participate in the Medical and Dependent Care Expense Reimbursement Plan for that Plan Year. If you do not complete a new Compensation Reduction Agreement and return it to the Plan Administrator prior to the date required, you will be deemed to have elected **not** to participate in the Medical and Dependent Care Expense Reimbursement Plan for the Plan Year in question.

(4) How can I participate in the Premium Conversion Plan?

If you are not a member of an ineligible class of Employees as described below, you will be eligible to enter the Premium Conversion Plan as a Participant on the same date you become eligible for the Medical and Dental Insurance Plans. The Entry Date is the first day of the month following the date on which you satisfy the eligibility requirements.

Owner-employees, partners, and Employees who are considered as owning more than a 2% interest in the Employer in any year in which the Employer is an electing small business corporation are not eligible to participate in the Plan.

After you become a Participant, your participation in the Premium Conversion Plan is automatic if you are paying premiums for Employer provided Medical or Dental Insurance unless you waive participation before the beginning of the Plan Year. You can choose **not** to participate in the Premium Conversion Plan for all or any portion of a Plan Year by filing a waiver form with the Administrator. If you waive participation, your insurance premiums will be paid from after-tax dollars. You will be given a waiver form for the Premium Conversion Plan when you are first become a Participant and before the beginning of each subsequent Plan Year. If you do not waive participation prior to the date required for such waiver, you will be deemed to have elected to participate in the Premium Conversion Plan with regard to Medical and Dental benefits for the Plan Year in question and your premiums will be paid with before tax dollars.

(5) What is the Plan's notice procedure?

During each enrollment period, the Administrator will give you a written notice concerning the Plan. The enrollment period ordinarily begins approximately 60 days prior to the first day of the Plan Year. New Employees may be given an opportunity to enroll or waive participation in the Plan or in any part of the Plan before their eligibility date. If you do not elect to participate in the Plan or any part of the Plan, or if you are deemed not to have elected to participate, you will not be eligible to again become a Participant until January 1st of the next Plan Year, unless there is a change of family circumstance during the year.

(6) What are the general rules regarding the Medical Care Expense Reimbursement Plan?

Under the Medical Care Expense Reimbursement Plan, you may submit reimbursements for medical expenses not covered by medical insurance and save taxes at the same time. The account allows you to be reimbursed for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those allowed under Sections 105 and 213(d) of the Internal Revenue Code. A list of covered expenses is available from the Administrator. Note that long-term care expenses are not considered medical expenses for this purpose. However, out-of-pocket medical expenses does include amounts expended for antacids, allergy medicines, pain relievers, and cold medicines without a physician's prescription, as well as any other amount that is considered reimbursable under IRS guidelines. The maximum you can contribute for Medical Care Expense Reimbursement each Plan Year is $3,000.

The Medical Care Expense Reimbursement 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 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).

(7) What are the general rules regarding the Dependent Care Expense Reimbursement Plan?

The Dependent Care Expense Reimbursement Plan can be used to pay for work-related dependent day-care expenses. If you are married, you can use the account if you and your spouse work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include (a) a dependent (day) care center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws; (b) an educational institution for pre-school children, provided that for older children, only expenses for non-school care are eligible; and (c) an individual who provides care inside or outside your home, provided the individual is not a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification

number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you.

(8) What is the procedure for filing a claim for reimbursement?

In order to be reimbursed for medical care or dependent care, you must submit to the Claims Payor an itemized bill and evidence that the amount will not be paid by any insurance company or other medical plan. The Claims Payor is the Plan Administrator. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return.

In lieu of submitting a claim to the Administrator, you may instead use the debit card issued by the Plan, provided that you certify upon enrollment, and during each subsequent re-enrollment period, that the card will only be used to pay for deductible medical expenses. Any payments made with your card will result in a corresponding reduction in your Medical Care Expense Reimbursement Account. If you use the card to pay for a non-reimbursable medical expense, you must repay that amount to the Plan, and the Plan Administrator can deny you the right to use the card further until repayment has been made.

(9) What happens if my compensation reduction during the year for Medical or Dependent Care Expense Reimbursement exceeds my expenses for the year?

The amount credited to your Medical or Dependent Care Expense Reimbursement Account for any Plan Year will only be used to reimburse you for Qualifying Reimbursement Expenses incurred during that Plan Year, and then only if you apply for reimbursement on or before the 90th day following the close of the Plan Year (or 180 days after termination of employment if earlier). If any amount remains in your Medical or Dependent Care Expense Reimbursement Account for a Plan Year after all expense reimbursements are made, it will not be carried over to reimburse you for Qualifying Reimbursement Expenses incurred during a subsequent Plan Year and will not be available in any other form or manner but will remain the property of the Employer, and you will forfeit all rights with respect to such balance.

(10) Can my election be changed?

Once you have elected to participate in the plan (or to waive such participation), you cannot change your election during the plan year, unless you have a change in family status. A change in family status includes marriage, divorce, legal separation or annulment, death of a spouse or child, birth of a child, adoption of or placement for adoption of a child, termination or commencement of employment of a spouse, the taking of an unpaid leave of absence by you or your spouse, change of or to part-time or full-time employment status by you or your spouse, a change in the status of a dependent, or a change in the place of residence of you, your spouse or your dependent. Any change made as a result in a change in family status must be on account of and consistent with the change in family status. Under the Dependent Care Expense Reimbursement Plan, the fact that your dependent is no longer eligible for dependent care is also considered a change in family status.

In addition, if the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to this Plan, you have special rights to change accident and health coverage (other than the Medical Care Expense Reimbursement Plan) for you, your spouse, or your dependents. If you change your coverage due to your rights under HIPAA, you can make a corresponding change in your elections under the Plan. You can contact the Plan Administrator for additional information concerning any rights you may have under HIPAA.

If the cost of coverage increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit

package option with similar coverage, or revoke your election entirely; and if coverage under the plan is significantly curtailed or ceases, you may revoke your existing elections and elect on a prospective basis to receive coverage under another plan with similar coverage. In addition, if new coverage options are changed, you may elect any new option or elect another option, if an option has been eliminated.

You may not change your election under the Dependent Care Expense Reimbursement Plan if the cost change is imposed by a dependent care provider who is your relative.

If you terminate your participation in the Plan as a result of a change in family status, no further reductions will be made in your compensation. However, you will continue to be eligible for reimbursements for expenses incurred during the Plan Year up to the amount of your account.

If you continue to be employed but stop participating in the Medical and Dependent Care Expense Reimbursement Plan(s) or the Premium Conversion Plan during a Plan Year for any reason, and you do not have a change in family status, your compensation for each such benefit will continue to be reduced by the amount you elected until the end of the Plan Year. Your payments will be applied against Plan administration expenses, and you will not be entitled to benefits.

(11) What are the limitations on the amount of my compensation that I may elect to reduce?
You may reduce your compensation by the amount of your Dependent care expenses incurred during the year. However, you may not reduce your compensation for Dependent care expenses by more than $5,000 ($2,500 if married, filing separately) per year, or if your spouse is a student for more than 5 months of the year, the lesser of your spouse's earned income or $4,800. The annual amount of reduction permitted for medical expense reimbursement which you can elect cannot exceed the lesser of your earned income or $3,000. The limitation on premium conversion amounts is the monthly amount you must actually pay for insurance premiums. If the pre-tax cash compensation payable to you by the Employer is less than the amount of the deferrals you elect, you will be required to pay the difference to the Employer.

(12) How will my benefits be affected if I am a Highly Compensated or Key Employee?
If you are a Highly Compensated Employee or a Key Employee of the Employer, the Administrator may modify or terminate your participation in the Plan without your consent to the extent necessary to satisfy the nondiscrimination requirements of the Internal Revenue Code.

(13) What is the effect of my participation on my Social Security benefits?
Any reduction in your compensation that is applied to the payment of Plan benefits is not treated as wages and is not subject to Social Security taxes. Since your Social Security benefit will be determined in part on the basis of the wages you earn during your lifetime, this reduction in the total wages earned may cause your Social Security benefit to be slightly reduced.

(14) What is the effect of my participation on my retirement benefits?
Your benefits under any Employer-sponsored retirement plan will generally not be affected by your participation in this Plan. Contact the Plan Administrator for more information.

(15) What is my responsibility for the tax consequences of participation in this Plan?
While the Employer intends that the payments you make under this Plan will be excludable from your gross income for federal income tax purposes, it cannot insure this exclusion, or that any other federal, state, or local tax treatment will apply. It is your obligation to notify the Employer if you have reason to believe that any payment is not excludable from your gross income. If any pre-tax payment for benefits paid to you is disallowed by any federal, state, or local tax authority, you must reimburse the Employer for any liability it may incur for failure to withhold federal, state or local

taxes you would have owed if such payment had been made to you as regular cash compensation, plus your share of any social security tax that would have been paid.

(16) What happens to my benefits if I terminate service or take family or military leave?

If you take a leave of absence under the Family Medical Leave Act (FMLA) or the Uniform Services Employment or Reemployment Rights Act (USERRA), you can continue to participate in the Plan during your period of leave. Amounts previously deferred which would otherwise continue to be deferred under this Section if you were still employed may be paid to the Plan as a single lump sum at the beginning of each year (or expected leave period), or as monthly payments.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that you be given the opportunity to elect a temporary extension of health coverage (called continuation coverage) in certain instances (called qualifying events) where coverage under Medical Insurance Plan would otherwise end. You and your family may be required to pay up to 102% of the full cost to the health plan of this continued coverage. Your rights to COBRA coverage for benefits under the Medical Insurance Plan are described in more detail in the underlying policy or in the applicable summary plan description for the Medical Insurance Plan.

COBRA may permit you, your spouse, and your dependent children to choose continuation coverage under the Medical Expense Reimbursement Plan through the end of the year after a qualifying event occurs only if, as of the date of the qualifying event, you are entitled to receive a benefit during the remaining portion of the year which is greater than the maximum amount that the Plan would be permitted to require you to pay for the remaining portion of the year. *For example*, assume you elect to deduct $100 per month ($1200 per year) under the Plan. Assume further that as the date of the qualifying event on May 31 you have submitted $300 of reimbursable expenses. The Plan would be required to offer COBRA to you because your remaining annual maximum benefit of $900 ($1200 - $300) is greater than the $714 (7 months x 1/12 of the annual $1200 premium x 102%) charge permitted by COBRA for your coverage for the remainder of the year. If, however, you had submitted $1,000 of reimbursable expenses, you would not be entitled to COBRA.

You have a right to choose continuation coverage if you lose your coverage under the Plan due to one of the following qualifying events: (a) your termination of employment (for reasons other than gross misconduct); (b) a reduction in your hours of employment below the minimum required to participate in the Plan; or (c) under certain circumstances, you do not return to employment at the end of a leave under the Family and Medical Leave Act of 1993 (FMLA). Your spouse can choose continuation coverage if your spouse loses coverage due to one of the above three events or due to (a) your death; (b) divorce or legal separation; or (c) you become entitled to Medicare. Your dependent child can choose continuation coverage if that child loses coverage due to one of the above six events or due to that child ceasing to be a dependent under the terms of the Plan.

You or your family member must notify the Administrator of a divorce, legal separation, or a child losing dependent status within 30 days after the date of the event. The Employer has the responsibility to notify the Administrator of your death, termination, Medicare entitlement, or reduction in hours of employment. When the Administrator is notified that one of these events has happened, the Administrator will notify you of your right to choose continuation coverage. You will then have at least 60 days from the date you would lose coverage to inform the Administrator that you want continuation coverage. If you don't choose continuation coverage within the given time limits, your coverage under the Plan will end.

Continuation coverage may be terminated because (a) the COBRA premium is not paid on time (there is a grace period of at least 30 days for payment of the regularly scheduled premium); (b) a qualified beneficiary becomes covered under another group health plan after electing COBRA coverage; (c) a qualified beneficiary becomes entitled to Medicare after electing COBRA coverage;

or (d) the Employer ceases to provide any group health plan to any employee. If you are eligible for continuation coverage, you are permitted to change your election under the Medical Care Expense Reimbursement Plan as provided in the change of status rules described in this Summary.

(17) Can the Plan be amended or terminated?

The Employer has established the Plan with the intention and expectation that it will be continued indefinitely, but the Plan may be amended or terminated by the Employer at any time. Nothing contained in this Plan will limit the Employer's right, without notice to or consent from any employee, to amend or terminate any other benefit plan we maintain.

(18) What is the procedure for contesting a claim that has been denied?

If you think you are not receiving any benefits to which you are entitled under this Plan, you may file a written claim with the Administrator. Claims for benefits under the Medical and Dental Insurance Plans will be reviewed in accordance with procedures contained in the policies for such Plans and/or in the applicable summary plan descriptions. Claims for benefits under the Medical Care Reimbursement Plan and Dependent Care Reimbursement Plan will be reviewed in accordance with the following procedures:

(a) If you believe you are being denied a claim for reimbursement, you may file a claim in writing with the Administrator. If your claim is denied, you will receive a written (or electronic) notice from the Administrator within 30 days of receipt of the claim, provided all needed information was provided with the claim. The Administrator may use a one-time extension not longer than 15 days if the Administrator needs more time to process the claim, in which case the Administrator will notify you within the 30-day period following receipt of the claim that the 15-day extension is being used. The Administrator will also notify you within the 30-day period if additional information is needed to process the claim before a decision can be made, in which case you will have 45 days to provide the needed information. If all of the needed information is received within this 45-day time period and the claim is denied, the Administrator will notify you of the denial within 15 days after the needed information is received. If you fail to provide the needed information within this 45-day period, your claim will be denied. The denial will contain (1) specific reasons for the denial, (2) specific references to pertinent Plan provisions, (3) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (4) information as to the steps to be taken if you wish to submit a request for review.

(b) If you disagree with a claim determination after following the procedures in paragraph (a), you can contact the Administrator in writing to request an appeal. The request should include (1) the name of the patient or dependent; (2) the date or dates of the provided services; (3) the provider's name; (4) the reason you believe the claim should be paid; and (5) any documentation to support your request for claim payment. Your first appeal request must be submitted to the Administrator within 180 days after receipt of the claim denial. For appeals under the Medical Reimbursement Plan, a qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Administrator may consult with, or seek the participation of, medical experts as part of the appeal process. Your consent will be sought to this referral and the sharing of pertinent health claim information. Upon request and free of charge, you or your representative have the right to reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits. You will receive a written (or electronic) notice of the Administrator's decision on the appeal within 30 days from receipt of a request for appeal of a

denied claim. The decision will contain specific reasons for the denial and specific reference to pertinent Plan provisions.

(c) If you are not satisfied with the decision of the Administrator pursuant to the first appeal described in paragraph (b), you have the right to request a second appeal from the Administrator. This second appeal request must be submitted to the Administrator within 60 days from receipt of first appeal decision. You will receive written (or electronic) notice of the Administrator's decision regarding the second appeal within 30 days of receipt of a request for review of the first appeal decision. The decision will contain specific reasons for the denial, specific reference to pertinent Plan provisions, and information as to the steps to be taken if you wish to take legal action related to your claim.

(19) What are my rights under ERISA?

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) (but these rights and protections do not apply to the Dependent Care Reimbursement Plan, which is not covered by ERISA). ERISA provides that all Participants are entitled:

(a) To examine without charge at the Administrator's office and at other specified locations (such as work-sites and union halls) all Plan documents, including insurance contracts, collective bargaining agreements and copies of all Plan documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan objectives;

(b) To obtain, upon written request to the Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

(c) To receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

(d) To continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and (e) to review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

(e) To review any Plan documents which govern qualified medical child support orders.

ERISA also imposes duties upon the people responsible for the operation of the plan. These people, who are called fiduciaries, have a duty to do so prudently and in the interest of all Participants. No one, including the Employer, a union, or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your ERISA rights.

If your claim for benefits 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 Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials about the Plan and do not receive them within 30 days, you may file suit in a federal court. If you do so, the court may require the 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 Administrator's control.

If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in state or federal court. If you disagree with the Plan's decision or lack thereof concerning the

qualified status of a domestic relations order or medical child support order, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 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.

(20) What other rights do I have under Federal law?

If the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies to this Plan, the Plan is required to protect the confidentiality and privacy of individually identifiable health information, in which case the Plan and those administering it will use and disclose health information only as allowed by Federal law. If you have a complaint, questions, or concerns, please contact the Plan Administrator. In addition, as required by the Women's Health and Cancer Rights Act of 1998, you are entitled under the Medical Care Expense Reimbursement Plan to be reimbursed for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Contact the Plan Administrator for more information.

(21) Who do I contact with questions about the Plan or about my rights under ERISA?

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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.

(22) What other information should I have regarding the Plan?

The following general information is applicable to this Plan:

Plan Sponsor:	Synod of the Pacific 200 Kentucky St., #B Petaluma, CA 94952-2879 (800) 754-0669 / (707) 765-1772
Tax ID Number:	23-7217973
Plan Number:	501
Plan Administrator:	The Employer
Funding Method:	Benefits provided under the Synod of the Pacific Flexible Benefit Plan are paid out of the general funds of the Employer. No trust fund or other segregated fund has been established for this purpose.
Service of Process:	Synod of the Pacific is designated as agent for service of legal process with respect to the Plan.