STERLING & STERLING LLC FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

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Sterling & Sterling LLC maintains the Sterling & Sterling LLC Flexible Benefits Plan for the benefit of its eligible employees. The terms of the Plan are contained in a lengthy, legally worded document. This Summary Plan Description is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name and Number:

   Sterling & Sterling LLC Flexible Benefits Plan; Plan Number 501

2. Employer Name, Address and Identification Number:

   Sterling & Sterling LLC
   135 Crossways Park Drive
   Woodbury, NY 11797
   11-1957801

3. Plan Administrator and Agent for Service for Process:

   Sterling & Sterling LLC
   135 Crossways Park Drive
   Woodbury, NY 11797
   515 773-8645

4. Claims Administrator:

   The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

   You may submit your claims online at P&A's website, www.padmin.com, by logging into your P&A Account or by using your smartphone.

   Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 716 855-7105.

5. Plan Year-End:

   December 31

THE FLEXIBLE BENEFITS PLAN
OVERVIEW

The Plan gives you the opportunity to avoid taxes on the part of your earnings that you use to pay certain expenses: your share of the cost of insurance coverage you receive through your Employer; health care expenses that are not covered by insurance; and expenses for the care of your children or other dependents so that you are able to work. So that you and other eligible employees can enjoy the tax savings the Plan is intended to provide, the Plan is operated according to certain rules contained in the federal tax laws and regulations.

If you want to take advantage of the tax savings potential that the Plan offers, you will need to figure out the types and amounts of covered expenses that you will have each year. Then, you will need to complete an election form based on your determination. When you complete an election form, you will indicate the benefits that you want, and you will instruct your Employer to withhold from your pay any money needed to cover the cost of those benefits.

The following is a list of some of the more commonly asked questions regarding your Plan.

PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The Plan first went into effect on January 1, 1995. This Summary reflects the terms of the Plan as of January 1, 2016.

WHAT IS THE PLAN YEAR?

"Plan Year" refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on January 1 and ending on the following December 31.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

To be eligible for the Plan, you must be regularly scheduled to work at least 30 hours a week for the Employer and you may not be classified by the Employer as a Temporary Employee. Also, you may not be an owner of the Employer if it is taxed as a partnership for federal income tax purposes.

If you are an eligible employee, you qualify to elect benefits under the Plan by becoming a Plan "Participant" on the first day of the month after you complete 30 days of continuous employment with the Employer.

HOW DO I PARTICIPATE?

When you become a Participant, you will receive a form that you can use to elect the benefits that you desire.

PLAN CONTRIBUTIONS

HOW ARE BENEFITS PAID FOR?

You pay for your own benefits under the Plan with money that is withheld from your pay based on your election form. These pay reductions do not count as income for income tax or Social Security tax purposes (exception: *If you are a New Jersey taxpayer, the New Jersey state income tax will apply to any salary reductions that you elect*). This means that the Plan allows you to use tax-free dollars to pay for expenses that would otherwise have to be paid with money that has been included in your taxable income.

WHEN ARE CONTRIBUTIONS MADE TO THE PLAN?

Unless your Employer tells you otherwise, the cost of your benefits will be withheld each pay period on a pro rata basis over the course of the Plan Year.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED BY MY CONTRIBUTIONS TO THE PLAN?

Your Social Security benefits may be slightly reduced because, when your pay is reduced to cover your benefits under the Plan, the amount of contributions that are made to the federal Social Security system to provide you Social Security benefits also are reduced.

PLAN BENEFITS

WHAT BENEFITS MAY I CHOOSE UNDER THIS PLAN?

Insurance Premium Pre-tax Payment Option and Flexible Spending Account Options

The benefits under the Plan consist of the various categories of expenses that you may elect to pay for with money that is not subject to tax. If you want to pay for your share of the cost of insurance coverage you receive from your Employer through the Plan, elect the Insurance Premium Pre-tax Payment Option described below; if you want to pay for your uninsured health care expenses through the Plan, elect one of the Medical Expense Reimbursement Account Options described below; and if you want to pay for day care costs through the Plan, elect the Dependent Care Assistance Account Option described below.

If you elect benefits under one of the Medical Expense Reimbursement Account Options or the Dependent Care Assistance Account Option (together called the "Flexible Spending Account Options"), your contributions to pay for your expenses covered by that option will be credited to an account in your name. This "Account" is for record-keeping purposes only and does not involve any actual segregation of funds.

HSA Contribution Option

In addition, you may elect to reduce your salary by a specified amount and to have that amount contributed to your Employer's Health Savings Account. Any election to contribute to an HSA may be changed monthly.

WHAT BENEFITS ARE AVAILABLE UNDER THE INSURANCE PREMIUM PRE-TAX PAYMENT OPTION?

The Insurance Premium Pre-tax Payment Option enables you to pay your share of the premiums for coverage

under your Employer's group medical, dental and vision plans with funds that are not subject to tax.

Unless you file an election with the Plan Administrator before the beginning of a Plan Year on a form that is provided to you, you automatically will be enrolled in the Insurance Premium Pre-tax Payment Option portion of the Plan. This means that the amounts that are taken from your pay during that Plan Year to cover your share of the cost of your insurance coverage will not be subject to taxes.

WHAT BENEFITS ARE AVAILABLE UNDER THE "GENERAL PURPOSE" MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OPTION?

If you elect the General Purpose Medical Expense Reimbursement Account Option, you will qualify to be reimbursed for the cost of medical care for you, your Spouse or your Dependents that is not covered by any other health plan or policy. "Medical care" involves the diagnosis, cure, treatment or prevention of disease. Expenses for medical care include expenses for routine and extraordinary medical and dental examinations, vision exams and eye-wear, surgery, psychiatric care, hospitalization, insulin, drugs and medicines obtained by prescription, therapeutic, orthopedic and prosthetic aids and devices, and transportation primarily for essential medical care.

The largest amount of benefits that you may elect under this Option is the highest dollar amount that the law allows at the time of your benefits election-$2,550 as of January 1, 2016. The smallest amount that you may elect is $100.

WHAT BENEFITS ARE AVAILABLE UNDER THE "LIMITED PURPOSE" MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OPTION?

If you or your Employer contributes to an HSA for you for any Plan Year, you may not have a General Purpose Medical Expense Reimbursement Account for that Plan Year. However, you may elect benefits under the Plan's Limited Purpose Medical Expense Reimbursement Account Option.

With a Limited Purpose Medical Expense Reimbursement Account, you are only eligible to be reimbursed for dental care, vision care and preventive medical care expenses. "Preventive Care" includes annual physicals and blood tests, well-baby and well-child care, immunizations for adults and children, tobacco cessation and obesity weight-loss programs and certain screening devices.

The largest amount of benefits that you may elect under this Option is the highest dollar amount that the law allows at the time of your benefits election-$2,550 as of January 1, 2016. The smallest amount that you may elect is $100.

WHAT BENEFITS ARE AVAILABLE UNDER THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION?

If you elect the Dependent Care Assistance Account Option, you will be reimbursed for your qualified dependent care expenses. Only expenses that meet all the following conditions qualify for reimbursement:

1. The expenses were incurred for services rendered after the date you became a Participant.

2. Each individual for whom you incur the expense:

   (a) is either (i) a Dependent under age 13 whom you are entitled to claim as a Dependent on your federal income tax return or (ii) a Spouse or other Dependent for tax purposes who is physically or mentally incapable of caring for himself or herself, and

(b) lived with you for most of the calendar year.

3. The expenses are incurred for the care of a Dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services provided by a Dependent care center (*i.e.,* a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

5. The expenses are not for services provided by a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not for services provided by an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

Eligible expenses include the cost of babysitters, daycare centers, nursery schools, after-school programs, eldercare and day camps. The cost of overnight camp is not an eligible expense.

WHAT EFFECT WILL PARTICIPATION IN THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION HAVE ON MY RIGHT TO THE DEPENDENT CARE CREDIT ON MY TAX RETURN?

The amount of your expenses that are eligible for the federal dependent care credit must be reduced, dollar for dollar, by the amount of expenses that you pay through the Dependent Care Assistance Account Option under this Plan. Before choosing that benefit option, you should determine if you would save more money by choosing instead to use the full, unreduced tax credit amount.

ARE THERE ANY LIMITS ON THE AMOUNT THAT MAY BE EXCLUDED FROM MY PAY FOR DEPENDENT CARE ASSISTANCE?

In general, the amount of expenses that you may pay through the Dependent Care Assistance option is limited to $5,000 per *calendar* year ($2,500 if you are married but you and your Spouse file separate tax returns). However, the amount of expenses can never exceed your earnings for the year or the earnings of your Spouse, whichever is lower. Special rules apply in determining the earnings of a Spouse who is a student or incapable of caring for himself or herself.

WHO IS CONSIDERED A SPOUSE? A DEPENDENT?

Only insurance coverage for a Participant, a Participant's Spouse or a Participant's Dependent may be paid with funds that are not subject to tax, and only the medical expenses of a Participant, a Participant's Spouse or a Participant's Dependent may be reimbursed with funds that are not subject to tax.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state.

Relatives as Dependents

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement under the Medical Expense Reimbursement Account Option of the health expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of insurance coverage that may be elected under the Insurance Premium Pre-tax Payment Option and the benefits that may be elected under the Medical Expense Reimbursement Account Option, "Dependent" also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

Non-Relatives as Dependents

To qualify as a Dependent, a person who is not related to a Participant must:

1. Receive over 50% of his or her financial support from the Participant for the calendar year;

2. Have the same principal residence as the Participant for the entire calendar year; and

3. Be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

FLEXIBLE SPENDING ACCOUNT CLAIMS

HOW DO I RECEIVE FLEXIBLE SPENDING ACCOUNT BENEFITS?

There are two ways to receive payment of your Flexible Spending Account expenses under the Plan.

Electronic Payment Method

If you elect benefits under a Medical Expense Reimbursement Account Option or Dependent Care Assistance Account Option, the Administrator will issue a debit card for you to use. Then, as you have eligible expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office, a pharmacy or a day care center). If the provider accepts the card, the provider will swipe the card in a manner similar to the way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Plan's Claims Administrator.

These rules apply to your use of the debit card:

1. When you use the card to obtain benefits, you will be certifying to the Plan that you are using it only for payment of eligible expenses.

2. You are not excused from the legal requirement that every benefit payment by the Plan must be supported by information that shows who provided you with the eligible product or service, the date you received the product or service and the amount you paid for the product or service. If the information that the Claims Administrator receives electronically about an expense when you swipe the card to pay for that expense is not sufficient, then you will be required to provide the missing information.
3. You will not be required to provide any follow-up information for certain expenses that you have paid for using the card. These are: (a) expenses that match exactly a co-payment amount under your health insurance; (b) repeating expenses that have already been approved by the Plan such as prescription drug refills; and (c) expenses where the information that the Claims Administrator receives electronically when you swipe the card is detailed enough to adequately justify the payment without any further information from you.

4. If you are required to provide additional support for an expense and fail to do so or if the Claims Administrator determines that an expense was ineligible for payment, you will be required to immediately repay the Plan. If you do not repay the Plan, your Employer will withhold the amount involved from your paycheck and, if necessary, the Plan will reduce your right to the payment of future claims. Also, you will lose the right to use the card.

5. You will lose the right to use the card immediately if you become ineligible for the Plan, even though you may have the right to submit further claims after you lose eligibility.

Claim Form Submission Method

You can also obtain reimbursement for expenses allowed under the Flexible Spending Account Options by submitting reimbursement claim forms and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expense. A claim for dependent care benefits must include the name, address and taxpayer identification number of the dependent care service provider. In the case of a babysitter, the taxpayer identification number is the babysitter's Social Security number. It is your responsibility to maintain adequate records to verify these expenses.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

WHAT IS THE MAXIMUM AMOUNT I CAN RECEIVE WHEN I SUBMIT A CLAIM?

Medical Expense Reimbursement Claims

If, for any Plan Year, you make an election under the Medical Expense Reimbursement Account Option, the amount that you elect will be immediately credited to a Medical Expense Reimbursement Account in your name. Starting on the first day of that Plan Year, you will be entitled to be reimbursed for claims up to the entire elected amount (reduced by the amount of reimbursement that you've already received from your Account during that Plan Year) at any time during the Plan Year, even if the total salary reduction contributions that you have made to your Medical Expense Reimbursement Account are less that the total amount of claims that you have submitted.

Dependent Care Claims

The largest amount available to pay a claim that you submit under the Dependent Care Assistance Account option will be the amount that is credited to your Dependent Care Assistance Account at the time your claim is received.

Grace Period

If you have a Flexible Spending Account on the last day of a Plan Year and still have money credited to the Account after all of your claims for expenses during the Plan Year have been paid, the left over money may be used to reimburse you for any eligible medical expenses that you have during the first 2 ½ months of the following Plan Year.

WHAT IS THE DEADLINE FOR SUBMITTING CLAIMS?

The deadline for submitting Flexible Spending Account claims (*including claims for reimbursement of expenses that you have during the applicable Grace Period*) normally will be March 31st of the following Plan Year. See below, however, the special rule that applies if you become ineligible for the Plan after the Plan Year has begun.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

You will be notified in writing by the Claims Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claims Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. the reason or reasons that your claim was denied;

2. the specific Plan provision on which the denial was based;

3. a description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and

4. information on the steps that you must take to appeal the Claims Administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request

and at no charge, relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appealing a Claim Denial

If the Claims Administrator denies your claim or any part of your claim, you or an authorized representative of yours may apply to the Claims Administrator's Operations Manager for the Plan to review the denial. Your appeal must be made in writing within 180 days after you received notification from the Claims Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

Decision on Review

The Claims Administrator's Operations Manager will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Operations Manager may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. the specific reasons for the decision on review;

2. the specific Plan provision or provisions on which the decision is based;

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

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

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

WHAT HAPPENS TO MONEY LEFT IN MY FLEXIBLE SPENDING ACCOUNT?

Any amount that remains credited to a Flexible Spending Account at the end of the permissible reimbursement period for a Plan Year will be forfeited and used to offset the Plan's administrative expenses and future costs. Because your salary reduction contributions not used to reimburse you for expenses incurred in the Plan Year will be forfeited, it is important that you carefully determine the proper amount of your compensation to allocate to each account.

MID-YEAR CHANGES

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

If you take a leave of absence from your employment with your Employer, your election of benefits under the Plan will remain in effect if your compensation from your Employer will continue to be paid during that leave. If, on the other hand, your leave is unpaid, you will have the opportunity, before the leave starts, to revoke your election and, if desired, make a new election in accordance with the rules discussed below at the Section entitled, "May I Change My Benefit Election?"

If you take a leave of absence to which the Family Medical Leave Act of 1993 ("FMLA") applies, during the period of such leave you will have the option of continuing your coverage under your Employer's medical insurance plan and Medical Expense Reimbursement Account Option on the same terms and conditions as though you were still an active Employee (i.e., your Employer will continue to pay its share of the premium to the extent you elect to continue you coverage). You may do so by either paying your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or by prepaying all or a portion of your share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreeable to the Administrator. Upon return from FMLA leave, you will be permitted to reenter the Plan on the same basis on which you were participating prior to taking leave.

MAY I CHANGE MY BENEFIT ELECTION?

While you may change your election before the beginning of a new Plan Year, as a rule, you may not change an election of benefits during the Plan Year. However, if you experience any of the following events, you may revoke your election after the Plan Year has commenced and make a new election for the balance of the Plan Year:

1. *Change in Status*.

   (a) A change in your legal status (e.g., marriage, death of your Spouse, divorce, legal separation or annulment).

   (b) A change in the number of your dependents due to events such as birth, adoption, placement for adoption or death.

   (c) A termination or commencement of employment by your Spouse or Dependent.

   (d) A reduction or increase in the hours that you, your Spouse or your Dependent works, including a switch between part-time and full-time status and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan that you, your Spouse or your Dependent depend on the employment status of the individual and a change in that individual's employment status causes that individual either to become eligible or cease to be eligible under the plan, that change constitutes a Change in Status.

   (e) An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for a certain benefit (e.g., due to attainment of a certain age).

   (f) A change in the place where you, your Spouse or your Dependent work or reside.

If you wish to change your election based on a Change in Status, the change must be consistent with that Change in Status, under the following rules:

Your change of election will be considered to be consistent with a Change in Status only if the Change in Status results in you, your Spouse or your Dependent gaining or losing eligibility for a benefit (or particular benefit option) under a plan of your Employer or under a plan of your Spouse's or Dependent's employer, and the change of election corresponds with that gain or loss of coverage, or, if the Change in Status affects Dependent care expenses described in Code Section 129.

If the Change of Status is your divorce, annulment or legal separation, the death of your Spouse or Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, you may not make an election under the Plan to cancel accident or health coverage for any individual other than your Spouse involved in the divorce, annulment or legal separation, your deceased Spouse or Dependent or the Dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, since such an election would not correspond with that Change in Status. In addition, if you or your Spouse or Dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are nontaxable benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes available or is increased under the plan from which eligibility for coverage has been gained.

If you, your Spouse or your Dependent become eligible for COBRA continuation coverage, you may elect to increase payments under this Plan to pay for that coverage.

2. *Special Enrollment Rights*. If you become eligible to exercise any HIPAA special enrollment rights regarding group health plan coverage, you may change your election for the balance of the Plan Year and file a new election that corresponds with your exercise of those rights.

3. *Certain Judgments and Orders*. If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires that your child, or a foster child who is your Dependent, be covered under your Employer's health plan or the health plan of your former Spouse's employer, you may change your election to provide coverage for the child under your Employer's plan if the order requires it or change your election to cancel coverage for the child under your Employer's plan if the order requires your Spouse or former Spouse, or any other individual, to provide the coverage.

4. *Entitlement to Medicare or Medicaid*. If you, your Spouse or your Dependent becomes entitled to coverage under Medicare or Medicaid, you may cancel that person's coverage under your Employer's accident or health plan. In addition, if you, your Spouse or your Dependent loses eligibility for Medicare or Medicaid coverage, you may make an election to commence or to increase that person's coverage under your Employer's accident or health plan.

5. *Change in Cost or Coverage.* A change of cost or change of coverage with respect to non-cash benefits that may be elected under this Plan may be the basis for a change of election based on the following rules:

   (a) These rules do not apply to benefits under the Medical Expense Reimbursement Account Option.

(b) If the cost of any of your benefits increases or decreases during a period of coverage and, as a result, you are required to increase or decrease your payments for those benefits, your salary reductions contributions under this Plan will be adjusted accordingly, unless you make a change to your election under (c) below.

(c) If the cost of any of your benefits significantly increases during a period of coverage, you may elect either to increase your contributions to pay for the increased cost or to revoke your election and to receive instead coverage under another benefit option of the plan providing the benefits. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which you have not elected that benefit or benefit option, you may make a new election of that type of benefit or benefit option. If you have an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect the benefit option that has significantly decreased in cost.

(d) You may only change your election due to an increase in the cost of Dependent care assistance benefits if your Dependent care provider is not your relative.

(e) If your coverage under any benefit plan is significantly reduced or stops, you may make a new election going forward of any other coverage option available under that plan. Coverage under an accident or health plan is considered to be reduced only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(f) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your Spouse, former Spouse or Dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules or if that plan permits participants to make an election for a period of coverage under the cafeteria plan or other plan that is different than that under this Plan.

6. *Changes in Coverage Attributable to Spouse's Employment*. You may revoke a prior election and make a new election where there has been a significant change in benefit plan coverage for you, your Spouse or your Dependent related to your employment or the employment of your Spouse or Dependent, if that change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

7. *Revoking Insurance Premium Pre-tax Payment Option Election to Pay for Employer Group Major Medical Coverage Premiums.*

(a) If you were reasonably expected to average thirty hours of service or more per week and experience an employment status change such that you are reasonably expected to average less than thirty hours of service per week, you may prospectively revoke your election related to coverage under the group major medical plan of your Employer, provided that you certify that you and any related individuals whose coverage under the group major medical plan of your Employer is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage (as that term is used for purposes of the Affordable Care Act) that is effective no later than the first day of the second month following the month that includes the date as of which coverage under the group major medical plan of your Employer is revoked.

(b) If you are eligible to enroll for coverage in a government-sponsored health insurance Exchange during an Exchange special or annual open enrollment period, you may prospectively revoke your election related to coverage under the group major medical plan of your Employer, provided that you certify that you and any related individuals whose coverage under the group major medical plan of your Employer is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of coverage under the group major medical plan of your Employer.

The Administrator must be notified within 30 days of any such event or circumstance to make an election change, except if you become eligible for HIPAA special enrollment rights that may be exercised within 60 days after you become eligible, in which case the Plan Administrator must be notified of your election change within 60 days after you become eligible.

Even if you are permitted to change your election under these rules, you may not change your election for Flexible Spending Account benefits below the amount of such benefits already reimbursed for the Plan Year.

If you fail to submit a new election form for any new Plan Year, your election under the Insurance Premium Payment Option will remain the same as for the prior Plan Year, but you will be considered not to have elected any Flexible Spending Account benefits for the new Plan Year.

MAY MY ELECTION BE CHANGED WITHOUT MY CONSENT?

If the Plan Administrator determined before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any elections with or without the consent of the Employee.

WHAT HAPPENS IF I STOP WORKING FOR YOUR EMPLOYER OR I BECOME INELIGIBLE FOR THE PLAN FOR ANOTHER REASON?

You will lose eligibility for the Plan if you stop working for your Employer as an eligible type of employee. When you lose eligibility for the Plan:

1. Your contributions for benefits will cease.

2. If you had a Flexible Spending Account election in effect on the last day of your eligibility and still had money credited to the Account on that date, the remaining balance may be used to reimburse you for eligible expenses that you had in the current Plan Year before you lost eligibility. These remaining claims must be submitted within 90 days after you lost eligibility.

3. Any outstanding Grace Period claims that you may have (i.e., claims reimbursable from a Flexible Spending Account that you had in the previous Plan Year), must be submitted by March 31st of the current Plan Year.

CONTINUATION COVERAGE

ARE THERE ANY CIRCUMSTANCES UNDER WHICH I MAY CONTINUE TO RECEIVE

COVERAGE AFTER MY EMPLOYMENT TERMINATES?

COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under a group health plan. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you and to other members of your family who are covered under a plan when you would otherwise lose coverage.

The COBRA law generally applies to all "group health plans' maintained by an employer. However, the purpose of this section of the Summary is limited to **explaining the COBRA rules that could allow you to continue your Medical Expense Reimbursement Account after you lose eligibility for the Plan.**

COBRA Coverage

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or

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

Your Spouse will have a qualifying event if:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct;

4. You become enrolled in Medicare (Part A, Part B or both); or

5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct;

4. You become enrolled in Medicare (Part A, Part B or both);

5. You and your Spouse become divorced or legally separated; or
6. He or she stops being eligible for coverage under the Plan as a "Dependent".

Special Eligibility Rules Apply

Under special rules that apply to a "health flexible spending arrangement" like a Medical Expense Reimbursement Account Option, the Plan may only be required to offer COBRA coverage if you have a positive Account balance in your Medical Expense Reimbursement Account at the time the qualifying event occurs. You will have a positive Medical Expense Reimbursement Account balance at the time a Qualifying Event occurs if your total contributions to the Account for the Plan Year to date are more than your total reimbursements from the Account (including for this purpose, any claims that have been submitted but not paid) for the Plan Year.

Notifying the Plan Administrator of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), your Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

How to Provide Notice

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

The Plan's form titled, "Notice of Qualifying Event", should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

See the information below regarding how the occurrence of a second qualifying event may affect the length of COBRA continuation coverage that is available. Any notice that you provide of a second qualifying event must include the same type of information that was included in your notice of the first qualifying event. The Plan's form titled, "Notice of Second Qualifying Event", should be used to notify the Plan Administrator of a second qualifying event. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days

after the second qualifying event occurs.

See the information below regarding how a determination by the Social Security Administration that a qualified beneficiary is disabled may affect the length of COBRA continuation coverage that is available. Any notice of disability that you provide must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination that he or she is disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form titled, "Notice of Disability Determination", should be used to notify the Plan Administrator of a disability determination. A copy of this form can be obtained from the Plan Administrator.
Your notice must be mailed within 60 days after the Social Security Administration makes its determination and before the end of the first 18 months of COBRA continuation coverage.

Electing COBRA Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately. Also, you or your Spouse may elect coverage for your minor children.

A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

Length of COBRA Coverage

When the qualifying event is your death, your enrollment in Medicare (Part A, Part B or both), your divorce or legal separation or your Dependent losing eligibility as a Dependent, COBRA coverage lasts for up to 36 months. When the qualifying event is the end of your employment or a reduction in your work hours and you became entitled to Medicare benefits less than 18 months before that qualifying event, COBRA coverage for other family members lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of your employment or reduction in your work hours, COBRA coverage generally lasts for up to 18 months. There are three ways in which this 18-month period of COBRA coverage can be extended.

Second qualifying event extension of 18-month period of COBRA coverage

An 18-month extension of coverage will be available to other family members if a second qualifying event occurs during the first 18 months of their continuation coverage. The maximum amount of total COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include your death,

your divorce, your enrollment in Medicare or a child losing status as a Dependent.

If a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days to obtain the extension.

Medicare extension for Spouse and Dependents

If your employment ends or your work hours are reduced within 18 months after you become entitled to Medicare, the maximum coverage period for your Spouse and Dependents will end three years from the date you enrolled in Medicare.

Disability extension of 18-month period of COBRA coverage

An 11-month extension of coverage may be available if you or another family member receiving COBRA is disabled. For the extension to be available, the Social Security Administration ("SSA") must determine that the family member was disabled during the first 60 days of COBRA coverage, and you must notify the Plan Administrator of that fact in writing within 60 days after the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability extension is available, it will apply to the COBRA coverage of all family members, not just the disabled family member.

You must notify the Plan Administrator within 30 days if the SSA determines that the family member has stopped being disabled at any time before the extension coverage period ends. COBRA coverage for all qualified beneficiaries will terminate when this occurs. The plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Special Rules May Shorten Your COBRA Continuation Coverage

Under special rules that apply to a "health flexible spending arrangement" like a Medical Expense Reimbursement Account Option, the Plan may only be required to offer COBRA coverage to you or your family members until the end of the Plan Year in which you lose coverage under the Flexible Benefit Plan's normal eligibility provisions.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) your Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of COBRA coverage

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

Payment for COBRA coverage-First payment

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Payment for COBRA coverage- Periodic payments

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Grace periods for periodic payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the Plan Administrator**,** or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA

A federal law known as "USERRA" may require that Participants who cease to be eligible to receive health care coverage because of duty in the uniformed services be given the right to buy continued health coverage on an after-tax basis for up to twenty-four months. USERRA also requires that for Participants who are expected to perform service in the uniformed services for less than 31 days, your Employer may not require the Participant to pay more than his or her share, if any, of the premium. With respect to non-health plans, USERRA requires that Participants be given the right to continue participation in the plan on the same basis as any Participant on a non-military leave of absence. To the extent required by applicable federal laws, the Administrator will implement and administer the procedures designed to comply with federal laws requiring the provision of continued coverage and plan participation and will give you notice of your rights under these laws.

MISCELLANEOUS

WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A HEALTH REIMBURSEMENT ARRANGEMENT (“HRA”)?

If you have a health care expense that is considered an eligible expense for purposes of an HRA or a similar supplemental medical reimbursement plan as well as this Plan, the expense must be reimbursed by that other plan to the extent that you have not exceeded your benefit limit under that plan unless the other plan allows unused Account balances to roll forward from Plan Year to Plan Year.

CAN THE PLAN BE CHANGED OR TERMINATED?

Although the Employer presently anticipates the Plan continuing indefinitely, it has the right to amend or terminate the Plan at any time.

WHO PAYS THE COSTS OF THE PLAN?

The Employer pays the cost of Plan administration.

WHAT RIGHTS DO I HAVE UNDER THE LAW AS A PARTICIPANT?

Statement of ERISA Rights. Each of the Medical Expense Reimbursement Account Options under the Flexible Benefits Plan is an “employee benefit plan” for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). If you have elected benefits under one of those options, you are entitled to certain rights and protections under ERISA, including the right to:

Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required

by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

4. Continue your health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.

Prudent Action by Plan Fiduciaries

5. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

6 If your claim for a 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.

7. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

8. If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE

PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.