SUMMARY PLAN DESCRIPTION

PAYCHEX BUSINESS SOLUTIONS, LLC.

FLEXIBLE BENEFITS CAFETERIA PLAN

Revised effective January 1, 2016

PLAN HIGHLIGHTS

Based on current tax laws, the dollars you elect to have deducted from your pay under the Cafeteria Plan are not subject to federal income taxes, nor generally to state or local income taxes. The Plan consists of three main parts: a contribution payment election and two flexible spending accounts (FSAs).

CONTRIBUTION PAYMENT ELECTION

- **The Plan enables you to make pre-tax payroll contributions toward the cost of the medical and pharmacy benefits and/or your dental plan benefits.**

FLEXIBLE SPENDING ACCOUNTS

1. Medical/Dental Reimbursement Account

- **The Plan enables you to pay eligible health care expenses not covered by any medical plan (including pharmacy) or dental plan with pre-tax dollars deducted from your pay.**

Eligibility to participate: 1st of the month following completion of the waiting period.

If you elect to participate in this flexible spending account option, you decide how much to contribute, up to the maximum set by the IRS.
Contributions are deducted on a pro-rata basis from the date you make the election.

2. Dependent Care Reimbursement Account

- **The Plan enables you to pay eligible dependent care expenses with pre-tax dollars deducted from your pay.**

Eligibility to participate: 1st of the month following completion of the waiting period.

If you elect to participate in this flexible spending account option, you decide how much to contribute, up to the maximum set by the IRS ($5,000 annually).
Contributions are deducted on a pro-rata basis from the date you make the election.

To participate in the flexible spending account options you must elect:

1) on or before the first of the month following the date you become eligible, 2) within 30 days after experiencing a "permitted election change event" also called a corresponding qualifying event, or 3) during an annual Open Enrollment period.

IMPORTANT LIMITATIONS: Choose the amount you elect to contribute to each FSA carefully. The accounts are subject to strict IRS rules, including the following:

- Your contribution election cannot be changed during the Plan Year (which is the calendar year) unless you experience a permitted change in election event, also called a corresponding qualifying event. Your request must be made within 60 days of such qualifying event.
- You will forfeit any contributions left in either account if they have not been used to reimburse you for eligible expenses incurred during the Plan Year in which the contributions are made. **However**, because of the carryover provision, you may carry over up to $500 of your current year's Health FSA balance to the subsequent plan year. Any amount above $500 will be forfeited.
- The deadline for submitting all claims for reimbursement is March 31 following the end of the Plan Year.

These and other Plan limitations are explained in this Summary Plan Description which provides a detailed description of significant Plan provisions.

Capitalization: The note on page 6 provides information about the capitalization of the first letter of words not normally capitalized.

If you have questions about your PBS benefits, call the Dedicated Service Center at 877-244-1771 or email paychexbenefitaccount@paychex.com.

Paychex Business Solutions Flexible Benefits Plan

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The following explanations are available:

- Flexible Spending Account (FSA)
  - Reimbursement claims submission options: debit card and manual
  - Orthodontia Expenses
  - Account Balances and Claims Status
  - Direct Deposit Reimbursement
  - Flexible Spending Account “Carryover”
- Refer to the consumer website for the list of eligible expenses.

Your worksite employer has adopted the Paychex Business Solutions (PBS) Flexible Benefits Plan to provide you with an opportunity to select from among various benefit options made available under the Flexible Benefits Plan. You will be able to pay for the benefit options you select using pretax compensation (before federal income taxes or social security taxes are withheld). As a result, you will pay less tax and have more money to spend and save.

This is a summary of the principal features of the PBS Flexible Benefits Plan and, if offered at your worksite as a benefit option under the Flexible Benefits Plan, the Medical Expense Reimbursement Plan (referred to herein as the “Health Flexible Spending Account” or “Health FSA”), the Dependent Care Assistance Plan (referred to herein as the “DCAP”), and the Limited-Purpose Flexible Spending Account (referred to herein as the “Limited-Purpose FSA). This document is not a substitute for the actual plan documents, which should be referred to for answers to specific questions.

In the case of any conflict between the terms of this summary and the terms of the Flexible Benefits Plan, Medical Expense Reimbursement Plan, and Dependent Care Assistance Plan, the terms of the plan documents will control.

Terms such as “Plan Administrator,” “Participation Year,” and “Company” are used throughout the document and are defined in Appendix A. Any reference to the “Code” shall mean the Internal Revenue Code of 1986, as amended.

Cafeteria Plan

A Cafeteria plan offers a choice of cafeteria plan benefits in accordance with the provisions of Section 125 of the Internal Revenue Code, as specified in this Summary Plan Description. These benefits are provided for eligible employees permitted to participate in this plan of benefits. The participating employee's cost for Plan benefits elected are funded by employee salary deferrals (via payroll deduction).

A note on capitalization in this Summary Plan Description: Capitalization of the first letter of a word or phrase (except in section headings) which is not normally capitalized (such as "Flexible Spending Account" or "Dependent Care Reimbursement Account") indicates that it is a word or phrase that is defined in either the *Definitions* section of this description (on page 22) or, more often, in the section where the word or phrase is first used. The advantage of using these defined terms is that they each have an exact meaning that you can readily refer to and the meaning is the same whenever the term is used in this description.

What is the Cafeteria Plan?

The Cafeteria Plan provides you with a convenient, tax effective way to make your contributions toward the company-sponsored medical and dental plans. In addition, it enables you to use Pre-Tax dollars deducted from your salary to pay for eligible dependent care expenses and health care expenses not covered by your medical or dental plan.

We call it a "Cafeteria" Plan because you can choose one or more of the following options to meet your personal needs.

- Contribution Conversion Election
- Two Flexible Spending Accounts

What is the Cafeteria Plan's Contribution Conversion Election?

If you elect to participate in Company-sponsored medical or dental coverage, you also elect to make your contributions for the coverage with Pre-Tax payroll deductions. This is referred to as the Contribution Conversion Election.

What are the Cafeteria Plan's two Flexible Spending Accounts?

- **Medical/Dental Reimbursement Account.** You can make Pre-Tax contributions to an account set up in your name, and be reimbursed from this account on a "tax- free" basis for eligible medical and dental expenses which are incurred by you, your spouse and your eligible dependents, and are not covered by any other health care plan coverage, or enrolled in a Health Savings Account (HSA) with a High Deductible Health Plan (HDHP) or if your spouse is enrolled in an HDHP with an HSA, a Limited-Purpose FSA.

- **Dependent Care Reimbursement Account.** The need for dependent care assistance is a top priority for many working couples and single parents. To assist with this important need, you can make Pre-Tax contributions to a Dependent Care Reimbursement Account set up in your name, and then be reimbursed from this account on a "tax-free" basis for eligible expenses to care for certain dependents: day care for your dependent children under age 13, or adult day care for other dependent family members who are incapable of self-care. These dependents must have the same principal abode as you for more than one-half the year. They must also qualify as exemptions on your personal income tax return, or you must show that they would have qualified except for their income level or tax filing status; or if you are a custodial parent who is divorced or separated, you may qualify under IRS rules even though you cannot claim the exemptions. (See IRS Publication 503 for details.)

What do we mean by "Pre-Tax"?

Your contributions toward medical and dental plans and your contributions to medical/dental and dependent care Flexible Spending Accounts are generally not considered part of your income. They are not subject to federal income taxes, and in most states they are not subject to state or local taxes, based on current tax laws.The funds accumulated in your accounts can be used by you to reimburse yourself on a "tax-free" basis for qualified out-of-

pocket expenses. As required by tax laws, “pre-tax” contributions can only be taken on a prospective basis; any required retroactive contributions cannot be made on a “pre-tax” basis, except for changes made due to birth or adoption.

Who is eligible for the Cafeteria Plan?

An employee who is eligible to participate in any of the insurance benefit options made available under the Flexible Benefits Plan will be eligible to participate in the Flexible Benefits Plan.

Note: An employee who is a sole proprietor or who owns an interest in a partnership or an LLC
may not participate in the Flexible Benefits Plan.
In addition, an employee who is a shareholder-employee owning more than 2% of an S corporation may not participate in the Flexible Benefits Plan.

When can I enroll in the Contribution Conversion Election?

You are automatically enrolled in the Contribution Conversion Election option when you enroll in a medical or dental plan. If you waive coverage when you are first eligible, your next opportunity to enroll will be during the annual Open Enrollment period held each fall for medical coverage (and every other year for dental coverage), with coverage generally effective the following January 1st. You would also make your Contribution Conversion election at that time.

The only other time you may enroll for medical and/or dental coverage and make the Contribution Conversion election outside of the Open Enrollment period is if you have a “permitted election change event”, also called a corresponding qualifying event. (See the section “Can I change my enrollment and contributions when I have a corresponding qualifying event?".)

When can I enroll in the Flexible Spending Accounts?

Your FSA eligibility date is the first of the month following completion of the waiting period. If you wish to set up one or both Flexible Spending Accounts, you must enroll within 30 days following your eligibility date. If you decline enrollment at this time, you will have an opportunity to open a FSA during the annual Open Enrollment period, usually held each fall for an account effective as of the following January 1st.

The only other time you may open a Flexible Spending Account (outside of the Open Enrollment period) is if you have a corresponding qualifying event. (See the section “Can I change my enrollment and contributions when I have a corresponding qualifying event?" on pages 11 - 13.)

Why should I be careful in choosing the amount of my FSA contributions?

Flexible Spending Accounts are administered, by law, on an annual "use it or lose it" basis. This means that any money left in either account after March 31 following the end of the Plan Year (which is the calendar year) will be forfeited, so it's important to budget carefully. You want to contribute only as much as you think you'll be paying out-of-pocket during the Plan Year. Be careful not to over-estimate your expenses. The money you contribute during a Plan Year can only be used to reimburse you for expenses incurred during that same Plan Year. You have until March 31 following the end of the Plan Year to submit all claims for reimbursement. IRS Regulations do not allow PBS to return this "unused" money to you so any remaining money in your account(s) will be applied to Plan administrative costs.

However, because of the Plan's carryover provision, you may carry over up to $500 of your current year's Health FSA balance to the subsequent plan year. Any amount above $500 will be forfeited.

Cafeteria Plan's Principal Features:

	Eligibility	Enrollment	Dates Coverage May Become Effective	Plan Year	Changes in Contributions or Participation	Tax Considerations
Contribution Conversion Election	First of the month following completion of waiting period.	When you enroll in a Company-sponsored Medical or Dental Plan.	- First of the month following completion of waiting period. - Jan. 1st after Open Enrollment. - Date of corresponding qualifying event.	January 1 through December 31	-Changes made during the annual Open Enrollment are generally effective the following Jan. 1st. -Changes based on a qualifying event and made within 30 days of that event, are effective on the qualifying event date; retroactive deduct-ions (if applicable) are taken after-tax*.	-Contributions after timely Plan election are not subject to federal taxes including Social Security and Medicare or to most state and local taxes. -Benefits are not taxable under current tax laws.
Medical/Dental Reimbursement Account (FSA)	Same as above	-On or prior to the first day of the month following eligibility. -During Open Enrollment -Within 30 days after a correspond-ing qualifying event.	-Changes based on a qualifying event and made within 60 days of that event, are effective on the date the change is requested via the on-line web-site, subject to PBS approval.	Same as above.	Changes made during the annual Open Enrollment are effective the following Jan. 1st. -Changes based on a qualifying event and made within 30 days of that event, are effective on the date the change is requested via the on-line web-site, subject to PBS approval; retroactive deduct-ions are not allowed.	*Same as above*

Limited Purpose FSA	Same as above	When you enroll in a Health Savings Account (HSA) Program with a High Deductible Health Plan (HDHP) or when your souse is enrolled in an HDHP with an HSA.	Same as above	Same as above	Same as above	Same as above
Dependent Care Reimbursement Account (FSA)	Same as above.	Same as for Medical/ Dental Reimburse-ment.	Same as above.	Same as above.	Same as above	*Same as above*

* Refer to *"What do we mean by 'Pre-Tax'?"* for information about the birth/adoption exception.

How much money should I put into my Flexible Spending Accounts?

First you must decide if you want a Medical/Dental Account, a Dependent Care Account, or both. Then, you will have to decide how much to contribute to each type of FSA based on the expenses you expect to incur during the balance of the year (until December 31st) if you enroll mid-year, or during the next Plan Year if you enroll during Open Enrollment. As required by law, the accounting for each type of FSA is done separately. Any balance in your Medical/Dental Reimbursement Account cannot be used to reimburse you for expenses eligible under your Dependent Care Reimbursement Account, and vice versa.

What are the FSA annual minimums and maximums?

Accounts have an annual minimum of $26.00.

The annual maximum that you are able to contribute to the Medical/Dental Reimbursement Account is set by the IRS. This amount is re-evaluated annually.

The Dependent Care Reimbursement Account is limited to the maximum set by the IRS per calendar year, ($5,000 per household or $2,500 if married filing separately) subject to other statutory limitations. (See "What types of Dependent Care expenses can I be reimbursed for?".)

These maximums are subject to reduction during the year for highly compensated employees so the Plan can meet and pass legally required discrimination testing.

Carryover of Remaining Account Balance

If you have a Medical/Dental Reimbursement Account in 2016, the Plan allows you to carryover up to $500 of any amount remaining at the of the end of the 2016 plan year. Such carryover amount may be used to pay or reimburse medical expenses incurred during all of 2017. Any unused amount of more than $500 remaining at the end of 2016 will be forfeited.

Can I change the amount of my contributions during the year?

Once you have set your payroll deduction for the year, you cannot change the amount you contribute until the next Open Enrollment period, unless you have a corresponding qualifying event, as explained in the section "Can I change my enrollment and contributions when I have a corresponding qualifying event?".

What is the FSA enrollment process?

Newly eligible employees
You will receive Flexible Spending Account enrollment information during your new hire orientation, including instructions about online enrollment for the Medical/Dental and Dependent Care Reimbursement Accounts, and information about claim reimbursement, and a detailed explanation of how the Flexible Spending Accounts work. You will be instructed to enroll online for the account(s) you choose to open, and

to specify the amount you want to contribute to the account(s) each pay period.

Important: You must complete your elections on or prior to the first date of the month following the date you become eligible. Contributions will be deducted from the date you enroll through the end of the current plan year or until your eligibility ends.

Annual Open Enrollment
Both the Medical/Dental and Dependent Care Reimbursement Accounts are operated on a Plan Year (calendar year) basis. You must enroll each year in the reimbursement accounts you want to participate in. You select the accounts you want, and your payroll deduction amounts each fall during the Open Enrollment period. The choices you make are in effect for the Plan Year following that Open Enrollment period. If you take no action in the following plan year, an election identical to your previous year's election will automatically be made.

Can I change my enrollment and contributions when I have a corresponding qualifying event?

In addition to the once a year changes allowed during the Open Enrollment period, you can also increase, decrease, or discontinue your FSA payroll deduction(s) at any time of the year if you have a "permitted election change event" which is a *corresponding change in status* (called a "Qualifying Status Change") based on one of the qualifying events recognized by the Plan as outlined below.

Your change in benefits must be consistent with your change in status. An example of a consistent or corresponding change would be increasing the amount of your medical contributions upon the birth of a child who you add to your medical coverage.

Medical, Pharmacy and Dental Coverage

You may make corresponding changes to your medical, pharmacy, and dental coverage when you experience any of the following qualifying events which are applicable to you:

- Marriage, divorce, legal separation, or annulment
- Declaration of same-gender domestic partner relationship or termination of same- gender domestic partner relationship
- Birth, adoption or placement for adoption
- Dependent reaches eligible status or ineligible age or status
- Death of spouse, same-gender domestic partner or dependent
- Termination or commencement of employee or spouse's or same-gender domestic partner's employment or benefit coverage which affects benefit eligibility (this will require or allow a corresponding change to the spousal surcharge)
- Employee, spouse or same-gender domestic partner takes or returns from an unpaid leave of absence

- Employee's employment status change which affects benefit eligibility (for example, part-time under 20 hours to 20 hours or more, or vice versa)
- Significant employee cost increase or decrease (may permit a corresponding change)
- Change in coverage under spouse's or same-gender domestic partner's plan, for example if spouse becomes or ceases to be eligible to receive coverage under spouse's employer's plan (may permit a corresponding change under this plan)

In addition, effective April 1, 2009, under HIPAA portability rules, is required to permit special enrollment in two circumstances. The first new special enrollment opportunity adds loss of eligibility for Medicaid or coverage under a state children's health insurance program (SCHIP) to the types of coverage losses that can give rise to special enrollment rights. The second new opportunity arises if an employee or dependent becomes eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP. (States may offer such subsidies to eligible low- income children and their families.) We will provide you with an annual notice about state premium assistance subsidies.

Special enrollment under these two circumstances must be requested within 60 days after the termination of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

Medical/Dental FSA

You may make corresponding changes to your Medical/Dental FSA election when you experience any of the following qualifying events:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption or placement for adoption
- Dependent reaches ineligible or eligible age or status
- Death of spouse or dependent
- Termination or commencement of employee or spouse's employment or benefit coverage which affects benefit eligibility
- Employee's employment status change which affects benefit eligibility (for example, part-time under 20 hours to 20 hours or more, or vice versa)

Changes requested – often toward the end of the year – can be accepted and processed only if there are sufficient payroll periods remaining to cover the election Contributions are deducted from the date of the enrollment through the end of the current plan year.

Note: Same-gender spouses, same gender domestic partners, and their children are not eligible for FSA participation unless they are Internal Revenue Code Section 152 tax dependents.

Dependent Care FSA

You may make corresponding changes to your Dependent Care FSA election when you experience any of the following qualifying events:

- Marriage, divorce, legal separation, or annulment

- Birth, adoption or placement for adoption
- Dependent reaches ineligible or eligible age or status
- Death of spouse or dependent
- Termination or commencement of employee or spouse's employment which affects eligibility
- Employee's employment status change which affects benefit eligibility (for example, part-time under 20 hours to 20 hours or more, or vice versa)
- Changes made during a spouse's open enrollment period
- A significant change in the cost of dependent care
- A change in dependent care provider
- Return from a leave of absence

Note: Child care expenses for same-gender domestic partners children are not eligible for FSA reimbursement unless children are Internal Revenue Code Section 152 tax dependents.

You only have 30 days from the day you experience a corresponding qualifying event (the actual date of the event) to notify Corporate Human Resources that you wish to make a corresponding change to your benefit elections. If you do not notify Corporate Human Resources within 30 days, your next opportunity to make a change will be during the annual open enrollment period for an effective date of the following January 1st.

Contributions are deducted from the date of the enrollment through the end of the current plan year.

Also be sure you notify your worksite employer and/or PBS of any other changes that may affect your coverage such as: name change, address change, or change in dependents. You will be required to complete and submit the necessary paperwork (for example, medical, dental and/or FSA forms) prior to the end of 30 days.

What types of Medical/Dental expenses can I be reimbursed for?

You can be reimbursed from your Medical/Dental Reimbursement Account for eligible medical and dental expenses that are not covered by any health/dental coverage. Only eligible expenses not covered by any health/dental coverage may be reimbursed; they must be accompanied by appropriate receipts and/or statements. Frequently the expenses you may submit for reimbursement are your medical and/or dental plan deductibles, co-pays and co-insurance amounts not paid for by your medical or dental plan coverage.

Examples of eligible expenses:
- Prescription drugs taken as part of medical treatment.
- Insulin and related equipment and supplies.
- Eligible over-the-counter medications accompanied by prescription.

- Certain specified medical expenses (such as for blood pressure testing).
- Dental expenses.
- Vision care expenses, including vision exams, glaucoma testing, and eyeglasses/contact lenses; contact lens solutions.
- Hearing care expenses, including hearing aids and examinations for their prescription and fitting.
- Routine physical examinations and routine pediatric care, including testing and immunizations.
- Birth control items prescribed by your doctor.
- Orthodontia
- Refer to forms available on the consumer website for more information.

Expenses reimbursed through your Medical/Dental Reimbursement Account cannot be claimed as a deduction on your income tax return or reimbursed through any medical or dental plan coverage.

What types of Medical/Dental expenses are <u>not</u> reimbursable?

You cannot be reimbursed from your Medical/Dental Reimbursement Account for certain services and supplies; for example:

- Over-the-counter drugs and medications if not accompanied by an appropriate prescription, except for insulin and related equipment and supplies.
- Non-prescription vitamins, dietary and nutritional supplements.
- Cosmetic surgery/treatments or cosmetic dentistry.
- Custodial care in an institution.
- Health club dues unless prescribed by your treating physician for medical reasons.
- Premiums for other health/dental coverage you have (such as through your spouse's employer).

Refer IRS Publication 502, "Medical and Dental Expenses," also lists eligible expenses. If in doubt, check with the Claim Administrator before proceeding.

What types of Dependent Care expenses can I be reimbursed for?

- You may be reimbursed for the care of certain eligible dependents who reside in the same principal abode as you for more than one-half the year. In brief, an eligible dependent for this purpose is defined as:
    - a child under the age of 13 you can claim as a tax exemption, or
    - your spouse or other family member who is physically or mentally incapable of self-care, and qualifies as an exemption on your personal income tax return (or would have qualified except for their income level or tax filing status). (See IRS Publication 503 for details.)

  If you are divorced or separated, IRS rules may permit the custodial parent to claim child care expenses even though that parent cannot claim a tax exemption for the child.

- Dependent Care expenses are only reimbursable if the care is necessary for you (and your spouse, if applicable), to be gainfully employed, or to allow you to work if your spouse is a full-time student or totally disabled.

- The annual maximum amount that you can contribute to your Dependent Care FSA cannot be greater than your annual income or your spouse's annual income, whichever is less (or your annual income only, if you are single); and it cannot exceed $2,500 if you are married, reside with your spouse and file a separate federal income tax return.

- The Dependent Care must be provided by:
    - a dependent care center which complies with applicable State and Local regulations, or
    - any caregiver, inside or outside your home, except your dependents, your spouse, or any other of your children under age 19.

What types of Dependent Care expenses are not reimbursable?

You cannot be reimbursed for dependent care services provided outside the home, unless your dependent regularly spends at least eight hours each day in your home and is claimed as a dependent on your federal income tax returns.

You cannot be reimbursed for food or clothing, transportation, schooling for children in kindergarten or older, or for housekeeping not related to dependent care.

These are only the principal requirements which must be met for expenses to be reimbursable from your Dependent Care Reimbursement Account. Because your account contributions are made with "tax-free" dollars, the Internal Revenue Service determines what expenses are reimbursable. For this reason, you may wish to consult a tax advisor, or refer to IRS Publication 503, "Child and Dependent Care Expenses", before opening a Dependent Care Reimbursement Account. Refer to the consumer website for a more extensive list of eligible expenses.

How do I get reimbursed for my eligible Medical/Dental expenses?

If you have an eligible medical or dental expense that may be covered by your medical/dental coverage or your spouse's medical/dental coverage, you (or your provider) must first submit a claim to that benefit plan (or to both plans if you have dual coverage), and obtain an "Explanation of Benefits" (EOB) from the plan (or plans).

Then, if there is an amount that is not covered that you have to pay out-of-pocket (for example, a deductible or co-payment), one option is for you to file a claim for reimbursement for that amount from your Medical/Dental FSA Reimbursement Account. Any applicable EOBs must be submitted with your FSA claim form; follow the instructions on the claim form and submit for reimbursement.

The other option is that the Claim Administrator may make available to you a debit card program which you can use with participating providers to pay some of your eligible health expenses at the point of service without having to pay out-of-pocket. The debit card program allows you to pay the medical/dental provider directly using funds from your FSA.

The medical/dental debit card can be used at most pharmacies, and doctor and dental offices. All charges shall be conditional pending confirmation and substantiation.

If you choose the debit card as your method of reimbursement, you may be asked to substantiate (provided proof that the purchases are eligible expenses) your claims during the year so save your receipts, itemized statements and Explanation of Benefits (EOBs). According to IRS guidelines, the Claim Administrator is required to verify that all purchases are eligible expenses. If the Claim Administrator requests substantiation, you need to provide documentation that the purchases were eligible expenses.

If the Claim Administrator requests you substantiate a claim and you do not have or do not provide the necessary documentation or if the Claim Administrator later determines the purchase does not qualify as an eligible medical expense, you can: submit another claim to cover the expense (as long as it is from the same plan year) or you may reimburse your account for the outstanding transaction(s) by mailing the Claim Administrator a check.

If an amount is paid in error, the Claims Administrator may take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

The debit card program may eliminate the need for you to file a reimbursement form for these expenses, as described in more detail in Appendix A. The methods of reimbursement, however, are not available if you or your covered dependents also have other health (medical, pharmacy, vision, dental etc.) coverage – because coordination of benefits will be required. If you or your covered dependents have more than one health insurance and a coordination of benefits is required, you will need to be certain all benefits are paid before using the debit card for the final out of pocket cost.

What happens the first time I submit a claim for a Dependent Care expense?

During the first month you contribute to your Dependent Care Reimbursement Account, you will experience a “double payment”. (1) You will be contributing to the account through payroll deduction and (2) at the same time you will have to pay your first dependent care bills. You can expect that these dependent care bills will be payable before you receive your first Plan reimbursement.

What is the reimbursement procedure for Dependent Care expenses?

1. Pay the bill, and ask the dependent care provider for: an itemized, signed receipt (which clearly identifies provider, provider’s Social Security or tax identification number, dates of service, and expense amount).

2. Complete a dependent care FSA claim form (available from the Claim Administrator), and follow the instructions on the form.

Mail (or fax) the completed form and your receipts to the Claim Administrator at the address (or the fax number) shown on the claim form.

Please note: There is not a debit card available for Dependent Care FSA.

What is the reimbursement procedure for Medical/Dental expenses?

1. Pay the bill, and ask the medical, dental provider for an itemized receipt (including provider, date of service and expense amount), and any related Explanation of Benefits (EOB).

2. If your eligible expense is not paid with an FSA debit card, complete an FSA claim form (available from the Claim Administrator), and follow the instructions on the form. Mail (or fax) the completed form and your receipts to the Claim Administrator at the address (or the fax number) shown on the claim form. Include a copy of any related medical/dental plan EOB when claiming expenses not covered by such plan or plans. Claims may also be submitted using the Claim Administrator's website.

What is the schedule for claim payments?

Reimbursement will normally be issued 5 to 7 business days after the Claim Administrator receives notification of your request and documentation when necessary.

Are there deadlines for incurring Medical/Dental and Dependent Care expenses and for filing for reimbursement?

Yes. You must incur all claimed expenses by December 31st of the Plan Year (which is the calendar year) for which you elected your Flexible Spending Account, except terminated employees must incur all claimed expenses prior to their termination date, unless they elect COBRA – for their Medical/Dental Account and have 90 days from the end of the plan year to submit for reimbursement. (See "What happens if I leave Employment" and "Does COBRA apply to my Medical/Dental account after I leave Employment?".)

There is also a deadline for filing all claims for reimbursement. You can file claims for reimbursement at any time after the expenses are incurred during the Plan Year, but not later than March 31 following the end of the Plan Year.

The "Carryover" was added to the Plan for use with the FSA reimbursement accounts starting with the 2016 Plan Year. For more information about the "Carryover", refer to the consumer website for more information.

When is my Medical/Dental Reimbursement Account maximum available?

You can receive reimbursement for eligible incurred expenses up to your total annual maximum commencing immediately after the start date of your participation for the year. For example, assume you elect $1500 as your annual maximum, have contributed $500 into your account, and submit an itemized claim for $700. You will be reimbursed for the entire $700 even though you have only contributed $500 into your account. You will receive full reimbursement at the time you submit the eligible claim to the Claim Administrator, as long as your expense is equal to or less than your annual election. Any deficit in your account will be covered by your subsequent contributions.

Can reimbursement from my Dependent Care Reimbursement Account exceed my contributions?

You can be reimbursed up to the full amount that you have contributed to your account. If you request reimbursement for more than the amount in your account, you will be reimbursed up to your current account balance, with the remaining amount being reimbursed as your contributions accumulate. For example, if you submit a claim for $400 but you only have contributed $300 in your FSA, you will be reimbursed $300. You will be reimbursed the remaining amount of $100, after the next pay period, when your deposits accumulate. The reimbursement is made directly to you, and not your dependent care provider.

How do I find out the status of my reimbursement accounts or of a particular claim?

Claim information can be accessed on the FSA Employee website or by calling 877-244-1771.

Could my Social Security benefits be affected by my participation in the Cafeteria Plan?

Contributions you make to your Medical/Dental Reimbursement Account or your Dependent Care Reimbursement Account are not subject to Social Security (FICA) taxes. Thus, if you participate in either or both options, and your salary is at or below the Social Security taxable wage base, your Social Security wages for the year will be lower. This could mean that your future Social Security benefits might be slightly lower. For most people, the tax savings realized will more than outweigh any possible future reduction in Social Security benefits, but this is a decision you must make. Be sure to check with your own tax advisor.

Can I claim the same Medical/Dental expenses on my income tax returns?

Because your salary deferrals (contributions) under the Plan are generally not considered part of your income subject to income taxes, your expenses which are reimbursed under the Plan can generally not be claimed on your income tax returns. The benefits you receive under the Medical/Dental Reimbursement Account (as well as from the Dependent Care

Reimbursement Account) are not taxable in most jurisdictions as the laws are currently written.

However, because circumstances for individuals may be different, we cannot predict how your taxes might be affected by participating in the Plan. You should check with your tax advisor if you have questions.

Can I take a tax credit on my income tax return for the same dependent care expenses reimbursed under the Cafeteria Plan?

The information provided in the previous answer also applies to this question. You may be eligible for a credit on your Federal income tax return for qualified dependent care expenses, or you may elect to be reimbursed for those same expenses from your Dependent Care Reimbursement Account - but not both. Your choice does not have to be the same for each expense incurred during the year. Check with your own tax advisor.

What's the difference between using the Dependent Care Reimbursement Account and taking the tax credit?

The difference between the Dependent Care Reimbursement Account and the tax credit is that the Reimbursement account reduces your taxable income (and therefore the amount of tax you pay) while a tax credit directly reduces your tax payment. If you use the Dependent Care Reimbursement Account, it will reduce, dollar for dollar the amount you use to calculate your tax credit. So you will need to determine which of these methods is best for you. If your total dependent care expenses exceed the amount you receive from the Dependent Care Reimbursement Account, you may be able to claim the tax credit on the excess.

Depending on your adjusted gross income, you can generally apply 20-35% of your qualified dependent care expenses as a tax credit, up to the IRS limit which is:

- $3,000 for one eligible dependent, or
- $6,000 for two or more dependents

minus:

- your annual contribution to your Dependent Care Reimbursement Account,

and subject to:

- the IRS earned income limitations.

Based on current tax tables, most employees with a total household income of less than $25,000 and one eligible dependent may find it more advantageous to take the tax credit. For employees with two or more eligible dependents, the decision is more complicated. It is recommended that all employees consult a tax advisor before deciding which approach is best for them. IRS Publication 503 “Child and Dependent Care Expenses” explains the tax credit. Whether you choose reimbursement from the Dependent Care Reimbursement Account or take the tax credit, you will have to identify the name, address, and Social Security number or taxpayer identification number of your dependent care provider on your tax return.

What if my Medical/Dental or Dependent Care reimbursement claim is denied?

The participant can review the Claim Administrators website to determine when the claim is processed. If the claim is denied, the website will indicate the claim has been denied and the reason.

Eligibility information for all employees and dependents is supplied directly to the Claim Administrator. If you or a dependent have a claim denied based on eligibility information provided by PBS, please contact the Dedicated Service Center at 877-244-1771. (See the "Additional Information" section).

If you feel an improper decision has been made, you may contact the Claim Administrator within 180 days after receiving a denial notice. Be sure to state the reasons why you feel the denial in incorrect. The Claim Administrator will then reconsider the claim and give written notice of their final decision.

See the “Statement of ERISA rights” section for information about appealing denial of your claim within 180 days to the Plan Administrator.

What happens if I go on a Leave of Absence?

If you go on an approved Leave of Absence including a Family Medical Leave you will receive written communications from PBS specifying the effect of your leave on your employee benefits, and notifying you of your options and your responsibilities with respect to continued participation in your benefits including the PBS Benefit Plan. You will be sent the name and telephone number of who to contact with any questions.

What happens if I leave Employment?

Payroll deductions are, of course, discontinued if you leave Employment. You may continue to file claims for reimbursement from your Medical/Dental and Dependent Care Accounts, for expenses incurred while you were a participating employee.

Additionally, effective August 1, 2012 you may continue to file claims for reimbursement from your Dependent Care Reimbursement Account after your termination date as long as you meet all other eligibility requirements. With respect to your Medical/Dental Reimbursement Account, see the following section about keeping your account open longer by making post-tax (after-tax) contributions as permitted under COBRA.
Also note, if you are rehired within 30 days after termination of employment the elections you had prior to termination will be reinstated, and any missed payroll deductions must be made up. Access the consumer website or call the Dedicated Service Center at 877-244-1771 for more information.

Does COBRA apply to my Medical/Dental account after I leave Employment?

Once you leave employment you can no longer contribute pre-tax dollars to your Medical/Dental Reimbursement Account. However, in accordance with COBRA, you may keep your account open until the end of the year in which your employment is terminated by continuing to make post-tax (after-tax) contributions to it. This would enable you to be reimbursed from your account for eligible expenses incurred while you are making after-tax contributions under COBRA, as well as for eligible expenses incurred earlier in the year while you were making pre-tax contributions as an employee. This extension of coverage is available through COBRA Continuation Coverage.

You may elect continuation coverage up to 60 days following notification by PBS of the continuation provision. Coverage will be reinstated retroactive to the date of employment termination provided that required contributions are made within 45 days of the election to continue coverage

What about Plan changes or termination of the Plan?

Although we expect to offer the Cafeteria Plan indefinitely, we reserve the right to change or end the Plan at any time. In addition, future changes in state or federal laws, especially tax laws, may require us to change the Plan. If you are a "highly compensated" employee (as defined by the Internal Revenue Code), we reserve the right to reduce your FSA election to prevent the Plan from becoming discriminatory within the meaning of the federal tax law. If you have any question about benefits under the Cafeteria Plan, or about making an application for benefits under this Plan, please contact PBS. In most cases, this is all you have to do to get your question answered or the issue resolved.

Rescission in Event of Fraud

Any act, practice or omission by a Plan Participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan and the Plan may rescind coverage as a result. Any such fraudulent statements including on Plan enrollment forms and in election submissions will invalidate any payment or claims for services and will be grounds for rescinding coverage/services.

Definitions of some terms frequently used in this description

As indicated on page 6 of this Summary Plan Description, when the first letter of a word or phrase used in this description is capitalized – and such capitalization is not the normal practice - it means that the term has a definite meaning for Plan purposes when used in this description. Usually you will find that the meaning of the capitalized word or phrase is spelled out in the section where it is first used, and in addition, if needed, the meaning can be made clear by the context. As noted, the advantage of using these defined terms is that they each have meaning you can refer back to as necessary, and the meaning is the same whenever used in this description.

Some of these defined words or phrases, and the page numbers where first used in this description, are as follows:

Flexible Spending Accounts or FSAs – The Plan's two Flexible Spending Accounts are:

- Dependent Care Reimbursement Account or Dependent Care Account – page 7.
- Medical/Dental Reimbursement Account or Medical/Dental Account (or Limited Purpose FSA) – page 7.

Some other defined terms:

- Contribution Conversion and Contribution Conversion Election or Option – page 8.
- Qualifying Status Change – pages 11-13.

Annual Open Enrollment and Open Enrollment – This is the period of time, usually about 3 weeks during the fall each year, as announced by PBS, when eligible employees may elect to participate in the Plan for the following calendar year. In accordance with IRS regulations, employees may not elect to participate in the Plan or change their participation at any other time during the year, except for newly eligible employees or following a corresponding qualifying event.

Forms/explanations regarding eligible expenses and reimbursement can be found on the consumer website.

ADDITIONAL IMPORTANT PLAN INFORMATION

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, as amended, the following important Plan information, Statement of ERISA Rights and Claims Appeals Procedure are provided as part of the Summary Plan Description.

The benefits described in this Summary Plan Description are provided under a self- funded plan sponsored by Paychex Benefit Solutions, LLC., and are subject to the terms and conditions of the Plan Document.

A copy of the Plan Document is available for your review during normal working hours in the office of the Plan Administrator, or you may make arrangements in advance with the Plan Administrator for a copy to be made available for your review at an office of your Employer.

See Appendix A.

Statement of ERISA Rights

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

Examine, without charge, at the plan administrator's office and at other specified locations, such as work-sites, all plan documents, including insurance contracts and the latest annual report (Form 5500 Series) that is filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, copies of the latest annual report (Form 5500 Series) and a copy of the summary plan description for the plan. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.

Receive a copy of the procedures used by the plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue medical/dental reimbursement account coverage under the plan if there is a loss of such coverage as a result of a qualifying event as explained in the COBRA section of this summary plan description. This plan contains no preexisting conditions exclusions.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the

person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by call the publications hotline of the Employee Benefits Security Administration.

Claims Appeals Procedure

Appealing Denial of Claims – This Summary Plan Description contains information about your reporting claims for benefits. If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the employee by the Claim Administrator not more than 30 days after the claim is filed. Prior to the expiration of this 30 day period, the Claim Administrator may notify the employee that the period is being extended for 15 days because of matters beyond the control of the Plan. The written denial decision will:

(1) give the specific reason or reasons for denial;

(2) make specific reference to Plan provisions on which the denial is based;

(3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary;

(4) provide an explanation of the review procedure; and

(5) advise of the right to sue under ERISA following the adverse benefit determination.

On any denied claim an employee or his representative may appeal to the Plan Administrator for a full and fair review. The claimant may:

(1) request a review by written application (which must be submitted within 180 days of receipt of the claim denial);

(2) review pertinent documents;

(3) submit issues and comments in writing; and

(4) provide written authorization for the Claim Administrator to release any pertinent information required by the Plan Administrator for the purpose of making the final decision on the appeal (including claim and medical records, correspondence and any reports).

A decision on the appeal will be made by the Plan Administrator no more than 60 days after receipt of the request for review. The Plan Administrator will make the final decision and the employee will be notified by the Claim Administrator. If the decision is adverse, the written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based; and advise the employee that he/she may obtain relevant documents and information, and has the right to sue.

Notwithstanding any other provisions of the Plan Document, the Plan will be administered in accordance with the privacy requirements in the Health Insurance Portability and Accountability Act of 1996 and the regulations issued there under ("HIPAA"), with respect to protected health information ("PHI") as defined in the law.

Permitted Uses and Disclosures of Protected Health Information by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent that they are not inconsistent with HIPAA:

- For general administration, including Plan Sponsor functions under any administrative service agreement with a third party (such as EBS Benefit Solutions, Inc. or a successor) engaged to provide claim and other services to the Plan, and in particular to perform enrollment, eligibility, reporting, auditing, financial and billing functions, and to assist in Plan administration with respect to disputes, inquiries and other authorized benefit functions.

- As required for computer programming, consultation and other work done in respect to the computer programs and systems utilized by the Plan.

- Other uses related to Plan administration approved in writing by the Plan Administrator or the Plan Privacy Officer appointed by PBS pursuant to HIPAA requirements.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

Uses and Disclosures of Protected Health Information by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to legally executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

Sharing of Protected Health Information with the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Document has been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the preceding provisions of this amendment to the Plan Document;

- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Makes PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

- Make its internal practices, books and records related to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible;

- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

    (A) Employees to be Given Access to PHI: The following employees of the Plan Sponsor are the only individuals that may access PHI provided by the Plan: those employees involved in the plan administration activities of the Plan, including Employee Benefits, HR Employee Programs, HR Support Center, Welfare Benefits Administration, Corporate Counsel/Legal Affairs Manager, and Vice President/Privacy Officer.

    (B) Restrictions to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

(C) Mechanism for Resolving Issues of Noncompliance: If the Privacy Officer determines that an employee of the Plan Sponsor has acted in noncompliance with the Plan Document provisions outlined above, then the Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment, as appropriate. It is the responsibility of the Plan Sponsor to report acts of noncompliance to the Privacy Officer. The Privacy Officer shall document the facts of the violation, actions that have been taken to correct the cause of the noncompliance, any discipline imposed and any steps taken to prevent similar violations in the future.

Participants' Rights

Participants and their covered dependents will have the rights set forth in the Plan's HIPAA notice of privacy practices for protected health information and any other rights and protections required under HIPAA. The notice may periodically be revised by the Plan.

Privacy Complaints

All complaints raised by Plan participants or their covered dependents in respect to the use of PHI must be submitted in writing to the Privacy Officer. A response will be made within thirty (30) days of the receipt by the Privacy Officer of the written complaint. In the event more time is required to investigate or resolve any issues, this period can be extended by the Privacy Officer to ninety (90) days. The affected participant will be given written notice of any such extension and of the resolution of the complaint. The Privacy Officer shall have full discretion in resolving complaints and in making required interpretations and factual determinations. The decision of the Privacy Officer shall be final and not subject to further review or appeal unless determined by competent legal authority to be arbitrary and capricious.

Written privacy complaints should be addressed to:

Paychex
Attention: Privacy Officer
911 Panorama Trail South
Rochester, NY 14625

The Administrator for the Plan retains full discretion in interpreting these rules and applying them to specific situations. All such decisions by the Plan Administrator shall be given full deference unless the decision is determined by competent legal authority to be arbitrary and capricious.

Special Enrollment Rights under SCHIP

Generally, you cannot change the elections you have made under the Plan after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections, and Federal law provides special enrollment provisions under some circumstances.

The Plan has been amended effective as of April 1, 2009 to provide for the following:

If an Employee has declined enrollment in the PBS Benefit Plan ("Health Plan") for him or herself or his or her dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in the Health Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Health Plan for him or herself or his or her dependents (including a spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Health Plan coverage, then there may be a right to enroll in the Health Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator. For other special enrollment rights, see the summary plan description for the Health Plan.

Compliance with HITECH and GINA

It is the intent of PBS that the Plan comply with the privacy and security requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Genetic Information Nondiscrimination Act ("GINA"), as of the required effective dates, with respect to the use and disclosure of protected health information, including GINA's mandate that genetic information, even if obtained inadvertently or in compliance with other statutes, is subject to HIPAA privacy requirements and must be kept separate from other medical information.

The Plan Administrator for the Plan retains full discretion in interpreting Plan rules and applying them to specific situations. All such decisions by the Plan Administrator shall be given full deference unless the decision is determined by competent legal authority to be arbitrary and capricious.

APPENDIX A

Name of Plans and Plan Numbers

Paychex Business Solutions Flexible Benefits Plan/Plan Number: 501
Paychex Business Solutions Medical Expense Reimbursement Plan/Plan Number: 501
Paychex Business Solutions Dependent Care Assistance Plan/Plan Number: 501

Employer whose Employees are Covered by the Plans (the "Company")

Paychex Business Solutions, LLC and/or its affiliates

Federal Employer Identification Number of Plan Sponsor (Paychex Business Solutions, Inc.)

59-2693969

Name, Business Address, and Telephone Number of the Plan Administrator

Paychex Business Solutions, LLC and/or its affiliates
970 Lake Carillon Drive, Suite 400
St. Petersburg, FL 33716-1129
(727) 556-2812

Name and Address of Agent for Service of Legal Process

Stephanie Schaeffer, Esquire
Paychex Business Solutions, LLC
911 Panorama Trail South
Rochester, NY 14625

(Service may also be made upon the Plan Administrator)

Plan Contributions
Contributions paid by employees through salary reduction elections

Plan Year for the Flexible Benefits Plan, Health FSA, and DCAP
January 1 to December 31

Participation Year of the Health FSA, and DCAP
January 1 to December 31

Type of Administration
The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the Plan Document. Claims are evaluated and processed as provided for in an agreement between PBS. and the Claim Administrator.

Plan Amendment Procedure
PBS, which may amend the Plan from time to time by a written instrument, reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice. PBS also reserves the right to change the employees' share of the Plan cost by the same procedures.