The Presbytery of Great Rivers of the Presbyterian Church (U.S.A.)]

Health Flexible Spending Arrangement and Dependent Care Spending Account

(describing healthcare expense and dependent care expense reimbursement benefits available to employees)

Effective January 1, 2015

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INTRODUCTION

The Health Flexible Spending Arrangement and Dependent Care Spending Account (the "Plan") was established to provide for the reimbursement of certain eligible Healthcare Expenses and Dependent Care Expenses of the eligible employees of The Presbytery of Great Rivers of the Presbyterian Church (U.S.A.)] ("Employer"). This document constitutes the Plan, effective as of January 1, 2015.

This Plan provides for the reimbursement of eligible Healthcare Expenses and Dependent Care Expenses.

Employer reserves the rights to alter, amend, modify, or terminate the Plan, in whole or in part, at any time for any reason in a manner consistent with the provisions of Article VII.

This Plan is sponsored by a church organization and is intended to be a church plan as defined in section 414(e) of the Internal Revenue Code, as amended ("Code"), that has not made an election under section 410(d) of the Code and is therefore exempt from the requirements of the Employment Retirement Income Security Act of 1974 otherwise applicable to such plans.

This Plan is intended to qualify as an "accident and health plan" within the meaning of section 105(e) of the Code and any other pertinent laws or regulations, so that the benefits provided under the Plan shall be eligible for exclusion from each Eligible Employee's income for federal income tax purposes under section 105(b) of the Code. The provisions of this Plan shall be interpreted in accordance with that intent.

As required by federal law, the marital status of an employee under this Plan must be determined by federal law, not state law. As a result, while a covered partner as defined under the Board's Benefits Plan may be entitled to coverage under those plans, only a spouse of an Eligible Employee as defined under Federal law will qualify for benefits as a spouse under this Plan unless the covered partner qualifies as a dependent under Section 152 of the Code.

This document, as it may be subsequently amended, shall constitute the Plan in its entirety. In the event any discrepancies exist between this document and any amendment, the amendment shall govern.

ARTICLE I

DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated hereto or amendment hereto, have the meanings set forth below. Words in the masculine gender include the feminine gender, and vice versa. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

Annual Enrollment Period

Annual Enrollment Period means the period of time preceding the beginning of each Plan Year during which Participants may elect coverage under the Plan.

Benefits Plan

Benefits Plan means the Benefits Plan of the Presbyterian Church (U.S.A.), administered by The Board of Pensions of the Presbyterian Church (U.S.A.).

Child Coverage Order

A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for the child of an Eligible Employee.

Claim Administrator

Claim Administrator means the person, persons, entity, or entities appointed by the Employer who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms.

*COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Church plans are exempt from certain COBRA requirements applicable to health plans. The Benefits Plan provides for medical continuation coverage that is comparable to COBRA coverage.

Code

Code means the Internal Revenue Code of 1986, as amended from time to time.

Dependent

Dependent means an Employee's covered partner and any individual who is considered a dependent of the Employee within the meaning of section 152 of the Code, as modified by statute, regulation, or otherwise.

Dependent Care Expense

Dependent Care Expense means any amount Incurred that is an expense under section 129 of the Code for the care of a qualifying individual to enable the employee and spouse to be gainfully employed. The Employer shall determine whether any other amount constitutes a Dependent Care Expense that qualifies for reimbursement hereunder.

Effective Date

Effective Date means January 1, 2015. The Effective Date of any amendment or restatement is the effective date specified in the amendment or restatement.

Eligible Employee

Eligible Employee means an individual who is an Eligible Employee within the meaning of Section 2.01.

Employer

Employer means The Presbytery of Great Rivers of Presbyterian Church (USA).

Enrollment Form

Enrollment Form means a form prescribed by the Plan Administrator for purposes of enrolling for coverage under the Plan, or for changing or waiving such coverage, including any applicable compensation reduction agreement relating to this Plan.

Healthcare Expense

Healthcare Expense means any amount Incurred that is an expense for medical care within the meaning of section 213(d) of the Code, excluding expenses reimbursed by any other healthcare plan, premiums paid for any other healthcare coverage, and other expenses for which coverage under this Plan is proscribed by the Code or other applicable law. The Employer shall determine whether any other amount constitutes a Healthcare Expense that qualifies for reimbursement hereunder.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Incurred

Incurred means the date healthcare services or supplies were provided. Healthcare Expenses are Incurred as of the date they are provided, and not the date they are formally billed or charged or the date they are paid.

Participant

Participant means any Eligible Employee who meets the requirements for participation under this Plan and for whom coverage is in effect under this Plan, or an individual who has elected continuation coverage under Section 3.04 and for whom coverage is in effect under this Plan.

Plan

Plan means the Health Flexible Spending Arrangement and Dependent Care Spending Account of Employer, as described herein and as amended from time to time.

Plan Administrator

Plan Administrator means the person, persons, or committee identified to serve as Plan Administrator in Section 6.01.

Plan Year

Plan Year means the period beginning January 1, 2015 and ending December 31, 2015 or a 12-consecutive-month period beginning on any January 1 thereafter.

Prior Coverage

Prior Coverage means coverage under a group health plan or health insurance coverage that is subject to the requirements of HIPAA, other than coverage under a plan maintained by the Employer.

Primary Medical Plan

Primary Medical Plan means the Medical Plan of the Presbyterian Church (U.S.A.) or such other group health plan offered by an employer than meets the minimum value of the Code Section 36(b(c)(2)(C)(ii).

Qualifying Change in Status

Qualifying Change in Status means, as determined by the Plan Administrator, subject to any restriction under applicable law, the occurrence of one of the following events:

(a) an event that changes Eligible Employee's legal marital status, including marriage, death of a spouse, divorce or dissolution of a marriage or qualified covered partnership, legal separation, or annulment;

(b) an event that changes the number of an Eligible Employee's Dependents, including birth of a child, adoption, or placement for adoption or death of a Dependent;

(c) a termination or commencement of employment, a commencement of or a return from a leave of absence, or a change in work site of an Eligible Employee, spouse, or Dependent of an Eligible Employee;

(d) a change in employment status of an Eligible Employee, Spouse, or Dependent of an Eligible Employee that causes the individual to become or cease to be eligible for this Plan;

(e) an event that causes the eligibility of an Eligible Employee's Dependent for coverage under this Plan to change, including attainment of a limiting age;

(f) a change in the residence or work site of an Eligible Employee, Spouse, or Dependent of an Eligible Employee; or

(g) another change that is determined by the Plan Administrator, consistent with the rules under section 125 of the Code and the regulations promulgated thereunder, to be an occurrence in the life or work of an Eligible Employee, Spouse, or Dependents that would permit the Eligible Employee to elect, waive, or change coverage under this Plan during the Plan Year, including certain changes in benefits coverage for the Eligible Employee, Spouse, or Dependent of the Eligible Employee, including the elimination of coverage, loss of availability of coverage, substantial decrease in coverage (including material changes in availability of network providers), or other similar fundamental loss of coverage as determined by the Plan Administrator.

Special Enrollment Event

Special Enrollment Event means, with respect to any Eligible Employee as required under HIPAA, as amended:

(a) the marriage of the Eligible Employee; or

(b) the birth, adoption, or placement for adoption of a child of the Eligible Employee; or

(c) the qualifying loss of Prior Coverage by the Eligible Employee, Spouse or a Dependent, so long as a statement is submitted to the Plan Administrator to such effect in accordance with the rules established by the Plan Administrator. For purposes of this definition, qualifying loss means:

(i) if the Prior Coverage is provided under COBRA or the Benefits Plan medical continuation coverage, the exhaustion of such coverage; or

(ii) if the Prior Coverage is not described in a statement as noted in Section (c), the loss of eligibility for such coverage or the termination of employer contributions toward the Prior Coverage; or

(d) the loss of eligibility for coverage in a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act; and

(e) eligibility for assistance with coverage under a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act.

Spouse

When used in this Plan, the term "Spouse" is limited to the federal definition.

ARTICLE II

ELIGIBILITY AND ENROLLMENT

*1.02 Eligibility

Individuals shall become eligible to participate in the Plan as follows:

(a) An individual who was an actively employed employee (including a teaching elder) on the day before the Effective Date shall be eligible to participate in this Plan beginning on the Effective Date.

(b) Each newly hired or reemployed active employee regularly scheduled to work at least 20 hours per week shall be eligible to participate in the Plan as of the first day after the commencement of employment.

(c) The term *Eligible Employee* does not include any employee who performs service for the Employer as a leased employee within the meaning of Code section 414(n) or 414(o), nor an employee who is an in-house temporary employee.

(d) No Eligible Employee shall become a Participant unless the Eligible Employee enrolls in accordance with the rules set forth in Section 2.02.

An individual is only eligible for enrollment for Healthcare Expense benefits if enrolled in a Primary Medical Plan.

1.03 Enrollment

An Eligible Employee may elect, waive, or change coverage under this Plan in accordance with and only in accordance with the provisions of this Section.

(a) Initial Enrollment

An individual who is newly eligible to participate in the Plan must complete an Enrollment Form to enroll in the Plan and commence participation in the Plan. Such Enrollment Form must be completed, executed, and returned to the Plan Administrator no later than 30 days after the individual has received the Enrollment Form. Such coverage will be effective as soon as administratively possible, but no later than 30 days after the completed Enrollment Form is received by the Plan. If the Plan Administrator does not receive a properly completed Enrollment Form by the last day of the applicable time period, the Eligible Employee shall not be covered under the Plan.

(b) Annual Enrollment Period

During the Annual Enrollment Period, an Eligible Employee may enroll for, waive, or change coverage, or modify the rate of his contributions by submitting a

properly completed Enrollment Form. Such new election shall be effective as of the first day of the following Plan Year. If the Plan Administrator does not receive a properly completed Enrollment Form by the end of the Annual Enrollment Period, the Eligible Employee shall not be covered under the Plan or, if already enrolled, effect any new elections.

(c) Qualifying Change in Status

(i) Subject to any provisions set forth in this Plan, an Eligible Employee shall be permitted to change coverage under this Plan during a Plan Year upon a Qualifying Change in Status.

(ii) If an Eligible Employee experiences a Qualifying Change in Status and the Eligible Employee completes, executes, and returns to the Plan Administrator an Enrollment Form within 30 days after the date of the event, the Eligible Employee may enroll for, waive, or change his coverage, provided that such election is consistent with the Eligible Employee's Qualifying Change in Status and the terms of this Plan. The election shall be effective as of the date the properly completed Enrollment Form is processed by the Employer.

(iii) There is no limit to the number of Qualifying Changes in Status that can occur during a Plan Year.

(iv) The Plan Administrator shall make all determinations as to whether a Qualifying Change in Status has occurred and whether a requested change in coverage is consistent with a Qualifying Change in Status. For purposes of making such a determination, the Plan Administrator may require an Eligible Employee to submit evidence that the Eligible Employee has incurred a Qualifying Change in Status and such other evidence as the Plan Administrator deems reasonable under the circumstances.

(d) For purposes of contributions to the Dependent Care Expense benefits only, an Eligible Employee shall be permitted to make a mid-year election change:

(i) If the change is on account of, or corresponds with, a Qualifying Change in Status; or

(ii) If the change is on account of, or corresponds with, certain changes in the cost and coverage of the dependent care, such as a change in the dependent care provider.

(e) Special Enrollment Rules

An Eligible Employee may elect to enroll for coverage when a Special Enrollment Event occurs in accordance with the rules specified under the Benefits Plan.

(f) Other Mid-Year Change Events

(i) If an Eligible Employee or Dependent of an Eligible Employee becomes entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under section 1928 of such Act, the Eligible Employee may change his or her election to cancel or decrease contributions.

(ii) If an Eligible Employee or Dependent of an Eligible Employee who is entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under 1928 of such Act, loses eligibility for such coverage, the Eligible Employee may elect to commence or increase contributions.

(iii) If a Child Coverage Order requires the covered partner or former covered partner of an Eligible Employee to provide accident or health coverage to the Eligible Employee's child, and the coverage is, in fact, provided, the Eligible Employee may change elections under the Plan.

(iv) If a Child Coverage Order requires the coverage of an Eligible Employee's child under the Plan, the Eligible Employee may change elections to account for the coverage.

(g) Any change made under this Section shall be effective prospectively only.

1.04 Default Coverage

In the event of a failure to elect coverage, the following rules shall apply:

(a) If a new Eligible Employee fails to submit a properly completed Enrollment Form by the date specified in Section 2.02(a), the Eligible Employee shall be deemed to waive coverage under the Plan for the balance of the Plan Year.

(b) If an Eligible Employee fails to submit a properly completed Enrollment Form or to elect coverage under this Plan by the end of the Annual Enrollment Period for a Plan Year, the Eligible Employee shall be deemed to waive coverage under this Plan for that Plan Year.

In either case, (a) or (b), the Eligible Employee shall be permitted to enroll for coverage in accordance with Section 2.02(b) during the next Annual Enrollment Period or in accordance with Section 2.02(c) and 2.02(d) following a Qualifying Change in Status.

Coverage provided by default under this section shall, for all purposes under the Plan, be treated as if it had been elected by an Eligible Employee.

1.05 Enrollment Forms

Subject to Section 6.03(h), no election by an Eligible Employee with regard to enrollment for coverage, a change in coverage, or the waiver of coverage shall be effective unless the election is made in writing on the prescribed Enrollment Form and the form is timely filed with the Plan Administrator.

ARTICLE III

TERMINATION OF BENEFITS

*2.01 Termination Date of Coverage

(a) An individual's participation in the Plan shall terminate as of the earliest of:

(i) the date of termination of this Plan;

(ii) the date as of which this Plan is amended to terminate benefits with respect to a classification of Employees of which the individual is a member;

(iii) the date as of which the individual fails to make any contribution required under this Plan for coverage when due;

(iv) the date as of which the individual elects to waive coverage under this Plan, provided that the election is made in accordance with the rules of Article II;

(v) the date as of which the individual dies, retires, or otherwise ceases to be an Eligible Employee; or

(vi) the date as of which the individual enters the armed forces of any country on active, full-time duty, subject to any right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, as such Act may be amended from time to time.

An individual whose coverage ceases under this Section, other than an individual who continues coverage pursuant to an election under Section 3.04, shall be entitled to reimbursements under the Plan for Healthcare Expenses and/or Dependent Care Expenses Incurred prior to the date of such cessation in an amount that does not exceed the lesser of: (i) the individual's Healthcare Expenses or Dependent Care Expenses, respectively, Incurred during the portion of such Plan Year in which he is a Participant; or (ii) the annual amount elected under the Plan for the reimbursement of Healthcare Expenses or Dependent Care Expenses, respectively, (less reimbursable Healthcare Expenses or Dependent Care Expenses that were Incurred in the Plan Year, while the individual was a Participant, and that have previously been reimbursed). However, if in the course of the Plan Year in which the individual's participation ceases, the individual resumes participation in the Plan, with respect to Healthcare Expenses or Dependent Care Expenses Incurred after the date of such resumption the annual amount elected by the individual for the Plan Year shall reflect that no contributions were made during the period when the individual was not a Participant, except as otherwise required by Section 3.02.

(b) An individual's participation in the Healthcare Expense benefits of this Plan shall terminate when the individual ceases to be enrolled in the Primary Medical Plan.

(c) If, as a result of a Qualifying Change in Status (or a change in the cost or coverage of dependent care) an individual who has been a Participant during a Plan Year elects to reduce his coverage under the Plan below the level most recently in effect, to the extent the change in election causes the total amount elected for the Plan Year to be less than the Healthcare Expenses or Dependent Care Expenses, respectively, of the individual for the Plan Year or increases the amount by which such expenses exceed such elected amount, the following rules shall apply:

(i) To the extent the Healthcare Expenses or Dependent Care Expenses have already been reimbursed, the election to reduce coverage shall not be effective.

(ii) To the extent the Healthcare Expenses or Dependent Care Expenses have been Incurred but not yet reimbursed, or have not yet been Incurred, they shall not be reimbursed.

(iii) In making the election to reduce coverage, the individual shall be deemed to acknowledge and accept the consequences of the reduction set forth in (a) and (b), above.

*2.02 Coverage Following Severance

Coverage for an individual shall cease during a period for which the individual is entitled to severance benefits from his Employer.

*2.03 Leaves of Absence

(a) An Eligible Employee who takes an unpaid leave of absence from his Employer shall continue to be an Eligible Employee to the extent and only to the extent provided in the personnel policies and practices of the Employer or elsewhere in this Plan.

An employee who is eligible to continue Plan participation during an unpaid leave of absence may elect to: (a) continue Plan participation during this period by making after-tax contributions to the Plan, thereby continuing coverage; or (b) cease Plan participation during the leave period.

If the employee elects to continue Plan participation during the leave period, the employee shall pay his contributions on an after-tax basis during the leave period according to the same payment schedule that applied immediately prior to his leave period. The employee shall remit contributions to the Employer on a timely basis during the leave period. While coverage under the Plan is continued during the employee's leave period, the full amount of elected coverage under the Plan

shall be made available to the employee at all times, including during the period of leave. If the employee fails to make timely payment of contributions during the leave period, his coverage under the Plan shall cease and he may not be reimbursed for claims Incurred during the remainder of the leave period.

If the employee elects to terminate coverage under the Plan during the period of leave, the employee shall not be reimbursed for claims Incurred during the leave period. Upon the employee's return to employment, his pre-leave coverage shall be reinstated automatically. Upon reinstatement, the employee may elect to: (a) resume pre-leave coverage levels and make up the full amount of payments missed during leave; or (b) resume coverage at a level prorated to account for the period of leave and pay his contribution amounts at the level in effect prior to the leave period. Upon reinstatement, coverage shall be reduced by the amount of reimbursements for claims Incurred prior to the period of leave.

(b) An Eligible Employee who takes a paid leave of absence from his Employer shall continue to be an Eligible Employee hereunder and shall continue to participate during his leave of absence on the same basis, subject to the same terms and conditions, as he had participated immediately prior to his period of absence.

(c) Notwithstanding the foregoing, an Eligible Employee may not receive reimbursement for Dependent Care Expenses Incurred during a leave of absence from his Employer, whether paid or unpaid, unless such absence is short and temporary, such as for vacation or minor illness.

2.04 Continuation Coverage

Eligible Employees shall be entitled to elect to continue coverage under this Plan in accordance with the rules established by the Employer, and any notices or other communications furnished by the Employer thereunder. Such coverage shall be provided only as required, and such coverage shall cease as soon as, and the premiums or dues shall be as great as, permitted by applicable law and the regulations promulgated thereunder.

ARTICLE IV

BENEFITS, FUNDING, AND CONTRIBUTIONS

*2.05 Provision of Benefits

The benefits available under this Plan for a Plan Year shall take the form of pre-tax reimbursement for Healthcare Expenses and Dependent Care Expenses Incurred during the Plan Year. A Participant shall be entitled to reimbursement under this Plan only for Healthcare Expenses and Dependent Care Expenses Incurred after his participation has commenced and before his participation has ceased.

2.06 Amount of Reimbursement

(a) At all times during the Plan Year a Participant shall be entitled to reimbursement under this Plan in an amount that does not exceed the anticipated amount to be allocated on his behalf under the Plan (or under his election under Section 2.02) for payment of Healthcare Expenses under the Plan for the Plan Year (less any previously reimbursed Healthcare Expenses), regardless of the actual amount then standing to the Participant's credit under the Plan for payment of Healthcare Expenses. Each payment hereunder shall be a charge against the amount available to pay Healthcare Expenses under the Plan.

(b) A Participant shall be entitled to reimbursement of Dependent Care Expenses under this Plan in amount that does not exceed the actual amount then standing to the Participant's credit under the Plan for payment of Dependent Care Expenses. Each payment hereunder shall be a charge against the amount available to pay Dependent Care Expenses under the Plan.

*2.07 Limitations on Reimbursements and Forfeitures

(a) Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement for Healthcare Expenses under this Plan for any Plan Year shall be limited to the smallest of the following:

(i) the Participant's Healthcare Expenses, respectively, for the Plan Year;

(ii) the amount elected by the Participant for the payment of Healthcare Expenses under the Plan for the Plan Year (less any previously reimbursed Healthcare Expenses); or

(iii) the annual maximum amount described in Section 4.04; and

(iv) by any limitation established with respect to the Participant pursuant to Section 4.06 or 8.02.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

To the extent the amount of contributions credited to a Participant's account for a Plan Year pursuant to his compensation reduction agreement and election of coverage under this Plan exceeds his Healthcare Expenses appropriately submitted for reimbursement for a Plan Year, the amounts credited to his account shall be forfeited and applied toward administrative expenses under the Plan.

(b) Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement for Dependent Care Expenses under this Plan for any Plan Year shall be limited to the smallest of the following:

(i) the Participant's Dependent Care Expenses, respectively, for the Plan Year;

(ii) the amount actually contributed by the Participant for the payment of Dependent Care Expenses under the Plan for the Plan Year (less any previously reimbursed Dependent Care Expenses); or

(iii) the annual maximum amount described in Section 4.04; and

(iv) by any limitation established with respect to the Participant pursuant to Section 4.06 or 8.02.

(c) All Healthcare Expense and Dependent Care Expense contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

To the extent the amount of contributions credited to a Participant's account for a Plan Year pursuant to his compensation reduction agreement and election of coverage under this Plan exceeds his Healthcare Expenses or Dependent Care Expenses, respectively, appropriately submitted for reimbursement for a Plan Year, the amounts credited to his account shall be forfeited and applied toward administrative expenses under the Plan. Employees may roll over up to $500 in unspent healthcare flexible spending to the next plan year.

*2.08 Annual Limits

(a) The annual maximum amount that a Participant may elect for the reimbursement of Healthcare Expenses through the FSA for any Plan Year shall be $2,500, or such other amount that the Employer shall prescribe and communicate to Participants (provided that such amount may not exceed $2,500). The minimum amount that a Participant may allocate for the reimbursement of Healthcare Expenses under the Plan for any Plan Year shall be [$____] or such other amount that the Employer shall prescribe and communicate to Participants.

(b) The annual maximum amount that a Participant may elect for the reimbursement of Dependent Care Expenses through the DCSA for any Plan Year shall be $5,000 ($2,500 in the case of a separate return filed by a married individual), or the Participant's or Participant's spouse's earned income, if lower. The minimum amount that a Participant may allocate for the reimbursement of Dependent Care Expenses under the Plan for any Plan Year shall be [$____] or such other amount that the Employer shall prescribe and communicate to Participants.

*2.09 Expense Reimbursement Procedure

Reimbursement of Healthcare Expenses and Dependent Care Expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Healthcare Expenses or Dependent Care Expenses under this Plan, a Participant must submit a written application to the Claim Administrator not later than **90 days** following the end of the Plan Year in which such Healthcare Expenses or Dependent Care Expenses were Incurred, in accordance with such rules, practices, and procedures as the Claim Administrator may specify, in its discretion, for the reimbursement of Healthcare Expenses or Dependent Care Expenses under the Plan.

The Claim Administrator reserves the right to verify to its satisfaction all claimed Healthcare Expenses and Dependent Care Expenses prior to reimbursement.

(b) Each request for reimbursement of Dependent Care Expenses shall include such substantiation as required by the Claim Administrator, which must include a description of the service provided, the date the service was provided, and the amount of the expense.

(c) Each request for reimbursement of Healthcare Expenses shall include such substantiation as required by the Claim Administrator, which may include the following information:

(i) the name, and address of the employee;

(ii) the name and date of birth of the person for whom the Healthcare Expense was Incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;

(iii) the name and address of the person, organization, or other provider to whom the Healthcare Expense was or is to be paid;

(iv) a written statement from an independent third party setting forth the type, purpose, date, and amount of the Healthcare Expense for which reimbursement is requested; and

(v) a statement that the Participant has not been reimbursed nor is reimbursable for the Healthcare Expense by insurance or otherwise, and that the Participant has not been allowed a deduction for such Healthcare Expense under section 213 of the Code.

The Claim Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence or certification of payment or of obligation to pay Healthcare Expenses. The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Plan. The Claim Administrator may require the Participant to provide written authorization to obtain information from the Benefits Plan or from any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his Dependents are enrolled.

(d) Expenses eligible for coverage under the Benefits Plan or under any group medical, HMO, dental, vision care, prescription drug, or other health plans in which the Participant or his Dependents are enrolled must be submitted first to all appropriate claim administrators for such plans in accordance with the rules of those plans, and be finally adjudicated under those plans, before the expenses are submitted to the Employer for reimbursement under the Plan.

(e) Subject to applicable law, the Employer may establish such rules as it deems desirable regarding the frequency of reimbursement of Healthcare Expenses and Dependent Care Expenses and the minimum dollar amount that may be requested for reimbursement.

2.10 Contributions and Funding

(a) Reimbursements for Healthcare Expenses and Dependent Care Expenses shall be financed out of contributions made by the Employer pursuant to Participants' compensation reduction agreements under the Plan.

(b) The amount that the Employer contributes, if any, based on Participant's compensation reduction agreement shall be in addition to other amounts that the Employer, in its sole discretion, decided to contribute toward the cost of the Plan. Such contributions shall be credited to the Participants' accounts, as applicable.

(c) Employer is not required by law to maintain, and does not maintain, actual separate and discrete accounts for Participants under this Plan. All payments shall be made from the general assets of the Employer, and no assets shall be earmarked or segregated for purposes of providing benefits.

(d) The Employer may establish rules in addition to those already prescribed hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis.

ARTICLE V

PAYMENT OF BENEFITS

2.11 Application for Benefits

To be entitled to payment of any benefits, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, the completion and filing of a written application and the provision of information, as described in Section 4.05.

2.12 Assignment of Benefits

Except to the extent provided in this Plan, no benefit payable at any time under this Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge, or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator, and the Employer.

2.13 Payment to Representative

In the event that a guardian, conservator, or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator, the Claim Administrator, and the Employer.

2.14 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Healthcare Expenses and Dependent Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Healthcare Expense or Dependent Care Expense shall completely discharge all liability of this Plan, the Claim Administrator, the Plan Administrator, and the Employer with respect to such expense.

2.15 Overpayments

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Healthcare Expenses or Dependent Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits

otherwise payable under the Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

2.16 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Claim Administrator, the Plan Administrator and the Employer shall have no obligation or duty to locate a Participant. In the event a Participant becomes entitled to payment under this Plan and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without any consideration to interest payments which may have accrued.

2.17 Missing Person

If, within two years after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

2.18 Fraudulent Claims

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, the Plan Administrator may without anyone's consent terminate coverage, and the Claim Administrator may refuse to honor any claim under the Plan.

ARTICLE VI

ADMINISTRATION OF THE PLAN

*2.19 Administration of the Plan

The Employer shall serve as Plan Administrator responsible for the administration of the Plan and shall be a named fiduciary of this Plan and shall make all determinations under the eligibility provisions set forth in Article II of the Plan. The Employer, acting as a named fiduciary or as Plan Administrator, may assign or delegate any of its responsibilities for administering this Plan or carrying out its provisions. To the extent of any such assignment or delegation, the assignee or delegate shall have all of the authority and powers of the Employer. Any action taken by the Employer assigning any of its responsibilities as Plan Administrator to specific persons who are directors, officers, or employees of the Employer shall not constitute delegation of the Employer's responsibility, but rather shall be treated as the manner in which the Plan Administrator (on behalf of the Employer) has determined internally to discharge such responsibilities.

2.20 Appointment of Claim Administrator

The Employer may appoint one or more Claim Administrators to process all or a designated portion of claims under this Plan in accordance with its terms. The person, persons, entity, or entities serving as Claim Administrator shall serve at the pleasure of the Employer. Each Claim Administrator shall have the authority and discretion to interpret the Plan with respect to its duties and to decide questions and disputes arising under the Plan with respect to such duties, which interpretations and decisions shall be final and binding for purposes of the Plan, subject to any right of Participants to appeal the interpretation and decisions under this Plan.

2.21 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

(a) to make claim decisions and benefit payments or direct the Claim Administrator to process all or a designated portion of claims and to make benefit payments to or on behalf of Participants entitled to benefits under this Plan;

(b) to have the authority and discretion to interpret the Plan, to decide questions and disputes, to supply omissions, to correct defects, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;

(c) to authorize its agents to execute or deliver any instrument or make payments on the Plan Administrator's behalf;

(d) to obtain from Participants and others, such information as shall be necessary for the proper administration of this Plan, such as proof of other coverage and financial data needed to determine if an individual qualifies as the Dependent of an Employee (e.g., income tax returns);

(e) to appoint committees with such authority and powers as the Plan Administrator deems necessary;

(f) to retain counsel, employ agents, and provide for such clerical, accounting, actuarial, consulting, claims processing, and other services as it deems necessary or desirable to assist it in the administration of this Plan;

(g) to retain the right, authority, and discretion to make claim payment and benefit decisions upon appeal to the extent it has the authority to make such appeal determinations under Section 6.04;

(h) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any election or other submission requiring a written form may be made telephonically or electronically and whereby elections or submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;

(i) to adopt rules for the administration of the Plan; and

(j) to maintain records of administration of the Plan.

No determination of the Plan Administrator or the Claim Administrator in one case shall create a bias or retroactive adjustment in any other case. Expenses for the administration of the Plan shall be paid out of forfeitures under the Plan.

2.22 Claims Procedure

The Claim Administrator shall review claims for benefits under this Plan and respond thereto within 30 days after receiving the claim. This period may be extended one time for up to 15 days. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification setting forth:

(a) the specific reason or reasons for the denial;

(b) specific reference to pertinent Plan provisions upon which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim;

(d) if an internal rule, guideline, or protocol was relied upon in making the determination, a copy of the rule, guideline, or protocol or a statement that it will be provided free of charge upon request; and

(e) an explanation of the claim review procedure set forth below.

The claimant or his duly authorized representative may request a full and fair review of the claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator.

The review of a claim by the Plan Administrator shall be subject to the following rules. The claimant or his duly authorized representative may review pertinent documents and may submit issues and comments, including without limitation appropriate evidence or testimony of an expert, in writing. The review will not afford deference to the initial adverse benefit determination. The review will not be conducted by the individual who made the adverse benefit determination or by that individual's subordinate. The Plan Administrator shall make a decision promptly, and not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, and specific references to the pertinent Plan provisions on which the decision is based.

In the event that the Claim Administrator or Plan Administrator does not make a determination with respect to a claim within the time limit prescribed by this Section, the claim or appeal of such claim decision shall be deemed denied.

2.23 Records and Reports

The Claim Administrator and Plan Administrator shall maintain all such books, accounts, records, and other data as may be necessary for the proper administration of this Plan.

The Plan Administrator shall make available to each Participant for examination at reasonable times during normal business hours such records under the Plan in its possession as pertain to him.

2.24 Coordination with Other Benefits Plan

To the extent necessary or appropriate, the Plan Administrator shall coordinate its authority and responsibility with the plan administrator or administrators of any other benefits plan sponsored by Employer in accordance with such rules as the Plan Administrator and such other plan administrator or administrators shall determine.

2.25 Fiduciary Duty and Care

All fiduciaries under this Plan, including the Claim Administrator and the Plan Administrator, shall discharge their respective fiduciary responsibilities solely in the interest of the Participants of this Plan for the exclusive purpose of providing benefits to

Participants and defraying the reasonable expenses of administering this Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and in accordance with the provisions of this Plan.

2.26 Limitation on Liability

A Plan fiduciary shall be entitled to rely upon information from any source assumed reasonably and in good faith to be correct. The Employer, Plan Administrator, and Claims Administrator shall not be subject to any liability with respect to his duties under this Plan unless it acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

2.27 Indemnification

To the extent permitted by law, the Employer shall indemnify and hold harmless each director, officer, or employee of the Employer to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent. The Employer may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any fiduciary responsibility with respect to this Plan from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan.

ARTICLE VII

DURATION AND AMENDMENT OF THE PLAN

2.28 Right to Amend

The Employer reserves the right to amend the Plan at any time, in any manner, including, without limitation, the right to amend the Plan to reduce, add to, or modify the type and amount of benefits provided for any and all Participants. Any amendment shall be formally adopted in writing. The Employer reserves the right to delegate this authority to amend, in whole or in part, to any committee, office, officer, or other person or persons as it deems appropriate.

2.29 Right to Terminate

Although the Employer intends to maintain this Plan for an indefinite period, the Employer reserves the absolute right to terminate or partially terminate the Plan at any time, for any reason by or pursuant to a resolution of the board of directors of Employer. Any termination or partial termination of the Plan shall not adversely affect the payment of benefits to which a Participant was entitled under the Plan prior to the date of termination or partial termination. If the Plan is terminated, each Participant shall be entitled to benefits for Healthcare Expenses and Dependent Care Expenses Incurred prior to the date of termination, provided that the Participant appropriately follows the terms of this Plan for reimbursement. Thereafter, the Employer shall have no liability or obligation to make any reimbursements under the Plan.

ARTICLE VIII

MISCELLANEOUS

9.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any of its employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of such an employee to perform fully his duties in a satisfactory and businesslike manner, nor shall it affect any Employer's right to discipline, discharge, or take any other action with respect to such an employee.

9.02 Legal Compliance

The Employer may prospectively limit, reallocate, or deny any benefit for a Participant or any group of Participants to the extent necessary to avoid discrimination under or otherwise comply with any pertinent provision of the Code or other applicable law.

9.03 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and, to the extent not superseded, with the laws of the State of Illinois. Benefits provided under this Plan are intended to be exempt from taxation under section 125 and 105 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable to church plans for purposes of retaining such tax exemption.

9.04 No Guarantee of Tax Consequences

Notwithstanding any provision of this Plan to the contrary, the Employer and the Plan Administrator make no commitment or guaranty that any amounts paid to or for the benefit or coverage of a Participant under this Plan shall be excludable from the Participant's gross income for federal, state, or local income tax purposes, or that any other particular federal, state, or local tax treatment shall apply or become available to any Participant as a result of the operation of this Plan. By accepting a benefit under this Plan, a Participant agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest or penalties that may be imposed in connection with the tax.

2.05 Family Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and

regulations thereunder, this Plan shall be operated in accordance with Treasury Regulation section 1.125-3.

2.06 Uniform Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

2.07 Invalid Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this _____ day of _____, 20____.

The Presbytery of Great Rivers of the Presbyterian Church (USA)

By: _____

Name:

Title: Corporate President / Chair - Administration Team