Apple Tree Dental
Group Benefits Wrap Plan
Summary Plan Description
Effective Date: January 1, 2014

INTRODUCTION

The Employer has created the Apple Tree Dental Group Benefits Wrap Plan effective on January 1, 2014.

Apple Tree Dental (the "Employer") has created the Apple Tree Dental Group Benefits Wrap Plan (the "Plan") for the benefit of its regular, full-time employees. The Plan is effective January 1, 2014, and includes the following Underlying Group Benefit Plans: Medical, Dental, Vision, Long Term Disability, Short Term Disability, Life Insurance, Voluntary Life for Employees and Dependents, Cafeteria Plan benefits that are provided for eligible employees and their families.

This Summary Plan Description is intended to explain the Plan in a way that you can easily understand. If you have any questions after reading this Summary Plan Description, please contact the Plan Administrator or the Employer.

These Underlying Group Benefits Plans are summarized in the booklets issued by the Employer or, if the benefits are insured, by the Insurance Companies. Copies of those booklets are attached to this document. A copy of each booklet is also on file at the Employer's office and may be read by you (or your lawyer) at any reasonable time. If you have any questions about either your Plan or this Summary Plan Description, you should ask your Plan Administrator.

This document, together with any Underlying Group Benefit Plan booklets issued by the Employer or Insurance Company constitutes the Summary Plan Description required by ERISA Section 102.

In the event of any differences between this Summary Plan Description and the actual terms of each Underlying Group Benefit Plan, the Underlying Group Benefit Plan's terms will govern.

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GENERAL INFORMATION ABOUT THE PLAN

Plan Name: Apple Tree Dental Group Benefits Wrap Plan

Type of Plan: The Plan provides welfare benefits under the following Underlying Group Benefit Plan: Medical, Dental, Vision, Long Term Disability, Short Term Disability, Life Insurance, Voluntary Life for Employees and Dependents, Cafeteria Plan.

Plan Year: The Plan Year is the twelve-consecutive-month period ending each December 31.

Plan Number: 525

Funding and Administration: Some Underlying Group Benefit Plans may be provided under group insurance contracts entered into between Apple Tree Dental and Insurance Companies. If so, claims for benefits are sent to the Insurance Companies, and the Insurance Company is responsible for paying claims, not Apple Tree Dental. Note that the Insurance Company and Apple Tree Dental would share responsibility for administering the plan.

The costs of the Underlying Group Benefit Plans, including Insurance premiums for employees and their families, are paid in part by the Employer out of its general assets, and in part by employees' payroll deductions as stated in the Underlying Group Benefit Plan booklets attached to this document.

Plan Sponsor: Apple Tree Dental

Affiliated Employers and TIN: A current list of affiliated employers is maintained by the Plan Sponsor.

Employer Name: Apple Tree Dental

Employer Address: 8960 Springbrook Drive, Suite 150, Coon Rapids, MN 55433

Employer Tax Identification Number (TIN): 36-3411437

Plan Administrator: Apple Tree Dental is the Administrator.

Named Fiduciary: Apple Tree Dental is the Fiduciary.

Agent for Service of Legal Process: Service may be made upon the Plan Administrator.

Plan Document: The written plan document required by ERISA Section 402 consists of a separately written document, together with any Underlying Group Benefit Plan descriptions and group insurance contracts entered into between Apple Tree Dental and any Insurance Companies.

> If the terms of this document conflict with the terms of any applicable Underlying Group Benefit Plan descriptions or Insurance Contract, the terms of the Underlying Group Benefit Plan descriptions or Insurance Contracts, rather than this document will control, unless superseded by applicable law.

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PART 1
DEFINITIONS

Here are some definitions that will help you better understand this summary of the Plan:

1.1 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act (COBRA).

1.2 "Eligible Employee" means an employee, partner and/or anyone with a ownership interest in the Employer, who is employed in the United States and who is eligible for the Underlying Group Benefit Plan(s).

1.3 "Employer" means the Employer stated above in the General Information section.

1.4 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

1.5 "Health Insurance" means a contract that requires your health insurer to pay some or all of your health care costs, under a Underlying Group Benefit Plan, in exchange for a premium.

1.6 "Information Form" means the agreement and form the Employer filled out and created this Plan.

1.7 "Insurer" means any insurance company that issues an Insurance Contract, or Underlying Group Benefit Plan. For this purpose, insurance company includes the Employer where the Employer self funds Benefits under this Plan.

1.8 "Insurance Contract" means any contract issued by an Insurer providing benefits under an Underlying Group Benefit Plan.

1.9 "Participant" means an Employee who has met the participation requirements specified in the Underlying Group Benefit Plan(s), and has not, for any reason, become unable to participate further in the Plan.

1.10 "Plan" means the Apple Tree Dental Group Benefits Wrap Plan, as it may be changed from time to time.

1.11 "Plan Administrator" the Plan Sponsor is the Plan Administrator.

1.12 "Plan Year" means the twelve-month period ending each year on December 31, or as specified by the Plan Administrator. The initial Plan Year is not a short plan year.

1.13 "Spouse" means one of the two people in a marriage, as defined by the applicable state or federal laws. The term spouse does not include Domestic Partners.

1.14 "Underlying Group Benefit Plan" means any of the benefits provided under this plan.

PART 2
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

2.1 Eligibility. To determine whether you, your spouse, dependents, children, or other family members are able to participate in the Plan, please read the eligibility information contained in the attached Underlying Group Benefit Plan booklets.

2.2 Ending Participation. Generally, your ability to get Plan benefits from an Underlying Group Benefit Plan stops on the day you stop meeting the requirements of the Underlying Group Benefit Plan, or on last day of the month in which you become ineligible for the Underlying Group Benefit Plan. See Underlying Group Benefit Plan's descriptions or booklet to determine when your benefits would stop. You may have the right to continue some of your benefits following certain "qualifying events" that would otherwise result in loss of the benefit. See the "Summary of Rights and Obligations Regarding Continuation of Group Health Plan Coverage," a copy of which has been previously given to you and your spouse (if covered under the Plan). Please contact the Plan Administrator if you need another copy.

PART 3
SUMMARY OF PLAN BENEFITS

3.1 Introduction. The Plan provides you with the following benefits under the Underlying Group Benefit Plans: Medical, Dental, Vision, Long Term Disability, Short Term Disability, Life Insurance, Voluntary Life for Employees and Dependents, Cafeteria Plan. A summary of the benefits provided under the Plan is in the attached booklets issued by the Employer or the Insurance Companies. This Plan will provide those benefits in accordance with the requirements of Federal and state laws.

3.2 Denial or Loss of Benefits. Your benefits (and your spouse's and dependent's benefits) under the Underlying Group Benefit Plan(s) will stop on the day you stop meeting the requirements of the benefit, or on last day of the month in which you become ineligible for the benefit. Your benefits will also stop upon termination of the Plan. Your benefits will stop if you fail to make any required premium payments.

Other circumstances that can result in the termination, reduction, loss, or denial of benefits are described in any attached booklets issued by the Employer or Insurance Companies, or in the Underlying Group Benefit Plan's Summary Plan Description. Please read these materials carefully.

3.3 Leaves of Absences and Family or Medical Leaves. If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), the way in which you participate in the Plan will depend on the policy of the employer, and whether or not you continue to get a paycheck from the Employer while you are on leave. If the Employer does not pay you while you are on leave, your participation in the Plan will be treated in the same way as if you had terminated your employment, unless the employer allows you to pay for benefits, on an after-tax basis while you are on leave. When you return to work your prior benefits may start again.

If you take a leave of absence that is a family or medical leave under the FMLA, you should contact the Plan Administrator in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave under the FMLA, you may continue to participate in the Plan, but you must continue your contribution. Contact the Plan Administrator to determine if the employer must follow FMLA rules.

Please contact the Plan Administrator as soon as you know you will be taking a Family or Medical Leave.

3.4 Qualified Medical Child Support Orders. A Qualified Medical Child Support Order ("QMCSO") is an order or judgment from a court, which, under certain circumstances such as divorce or child custody, requires an Employee to add one or more of their children as their dependent(s) under the Plan. A QMCSO may only be filed with respect to a child of a Participant in the Plan. If you are interested in more information relating to QMCSO and the procedures for filing them with the Plan, please contact the Human Resources Specialist.

PART 4
ADMINISTRATION OF THE PLAN

4.1 Plan Administration. The administration of the Plan is under the supervision of the Plan Administrator. The main duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the benefit of you and other people who meet the participation requirements.

The Employer is responsible for the administration cost of the Plan.

4.2 Power and Authority of Insurance Company. An Insurance Company that insures an Underlying Group Benefit Plan may be responsible for:

(a) Deciding eligibility for, and the amount of any benefits you may get under the Plan, and

(b) Creating claims procedures and claims forms to be used by you when filing a claim.

The party picked by the Plan Sponsor may also have the authority to require you to give it access to information that party determines is necessary for the proper administration of the insured Underlying Group Benefit Plan. This could include the release of all medical information needed to determine your eligibility, process claims, or for other Plan purposes.

4.3 Questions. If you have general questions regarding the Plan, please contact the Plan Administrator.

However, if you have questions concerning eligibility for and/or the amount of any insured Underlying Group Benefit Plan benefits payable under the Plan, please contact the Insurance Company.

PART 5
AMENDMENT OR TERMINATION OF THE PLAN

5.1 Amendment and Termination. The Employer has the right to change or stop the Plan, or any Underlying Group Benefit Plan, at any time and for any reason, without consent from you. You will be notified if there are any changes to the Plan or to any Underlying Group Benefit Plan. If the Plan, or an Underlying Group Benefit Plan, is changed, your rights from before the change will not be affected. Your rights for periods after the change will depend on the change. If the Plan, or an Underlying Group Benefit Plan, is stopped, your affected benefits will stop.

PART 6
BENEFITS FROM INSURANCE COMPANIES

6.1 Insurance Generally. Your benefits under an Underlying Group Benefit Plan are limited to the amounts determined by its Insurance Company. In order to get your benefits, you must satisfy all of the Insurance Company's requirements. The Plan Administrator has the right to change the coverage, carriers, or Insurance Contracts included under this Plan.

To get benefits from the insurer or HMO, you must refer to the respective Underlying Group Benefit Plan's Summary Plan Description, booklet, Certificate of Coverage or other documents provided by the Insurance Company or HMO. You must follow the claims procedures under each insured Underlying Group Benefit Plan. The insurance company or HMO will make a determination about your claim for benefits based upon reasonable claims procedures, as required by ERISA.

6.2 Differing Provisions. If any benefit under a Underlying Group Benefit Plan is provided through an insurance company, and there is any conflict or difference between the description of benefits contained in this document and the Insurance Contract, the terms of the Insurance Contract will control.

PART 7
STATEMENT OF YOUR RIGHTS

7.1 Your ERISA Rights. Certain benefits offered through the Plan are provided through the Underlying Group Benefit Plans which are ERISA welfare benefit plans. If you elect any of these benefits, you will be a participant in an ERISA welfare benefit plan, and, as such, you will have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants of ERISA plans are entitled to:

(a) Look at, without charge, at the Plan Administrator's office and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions,

(b) Receive copies of all plan documents and other plan information with written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies, and

(c) Receive summaries of the plan's annual financial report. The Plan Administrator may be required by law to furnish each participant with a copy of this summary financial report.

7.2 Fiduciary Obligations. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of ERISA employee benefit plans. The people who operate such plans, called "fiduciaries" of the plan, have a duty to administer the plan carefully and in the interests of plan participants and beneficiaries.

7.3 No Discrimination. No one, including the Employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

7.4 Right to Review and Filing a Lawsuit. If your claim for a benefit under an ERISA plan is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and re-evaluate your claim. Under ERISA, there are steps you can take to enforce the above rights.

(a) For instance, if you request materials that you are entitled to receive from the plan and do not receive them within thirty (30) days, you may file suit in a federal court.

(b) 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.

(c) If the plan fiduciaries misuse the plan's money or 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.

(d) In any of these cases, 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, in certain circumstances the court may order you to pay these costs and fees, for example, if it finds that your claim was frivolous.

7.5 Questions. If you have any questions about an ERISA plan, you should contact the Plan Administrator of that plan. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

7.6 USERRA Rights. If you, or your spouse or dependent, are absent from work for uniformed service, you may have the right to continue participating in one or more Underlying Group Benefit Plan(s) under the Uniform Services Reemployment and Rights Act (USERRA). USERRA is intended to lessen the difficulty that may occur if you need to be absent from your civilian employment to serve in the United States uniformed services. The Act seeks to make sure that those who serve their country can keep their civilian employment and benefits, and can seek reemployment without discrimination because of their service.

Under USERRA, employees absent for uniformed service (and their covered spouse and covered dependents) are eligible for continuation coverage for the period of service (plus time allowed under USERRA to apply for reemployment) or for up to twenty-four (24) months, whichever is less. If your service is for less than thirty-one (31) days, the plan may charge only your share of the monthly health care premium. If your service is more than thirty-one (31) days, the Employer may charge the full premium plus 2% (for a total of 102% of the premium). You may have rights under both COBRA and USERRA and are

entitled to the continued coverage that provides the more favorable benefit.

(a) An individual who serves in the military will be considered on leave of absence and will be entitled to all rights and benefits not determined by seniority that are generally provided to similarly situated Employees on leave of absence or other types of leave.

(b) The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA.

If you are eligible for continuation of benefits under USERRA you must inform the Employer and/or benefit Plan Administrator.

7.7 HIPAA Privacy of Your Medical Information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules require the Plan to take steps to protect any medical information that might identify you individually, and to allow you to have access to this information. Protected Health Information (PHI) is defined in HIPAA. For purposes of the Plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information that relates to your or their eligibility for benefits under the Plan.

The Plan will use and reveal PHI for purposes related to health care treatment, payment for health care services, and health care operations. The Plan will use or reveal PHI for any other purpose only upon permission from the individual. The Employer agrees:

(a) Not to use or further reveal PHI other than as permitted or required by the Plan document or as required by law;

(b) To make sure that any people, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

(c) Not to use or reveal PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) To be cautious of any use or disclosure of PHI and report to the Plan any use or disclosure that is inconsistent with the permitted or required uses or disclosures;

(e) To make your PHI available to you;

(f) To provide you with the opportunity to amend PHI if inaccurate;

(g) To provide you with an accounting of the disclosure of your PHI;

(h) To make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services for compliance purposes;

(i) To return or destroy all PHI, if possible, if not possible then limit further uses and disclosures;

(j) To make sure that plenty of separation exists between employees who are allowed to use PHI and those who are not, to describe those employees or classes of employees to be given access to PHI, to restrict the access to and use by these employees, and to provide an effective system for resolving any issues of noncompliance by persons who have access to PHI;

(k) That the Plan Administrator will create a system for resolving noncompliance issues for any individual described above who does not comply with the plan document, or improperly uses or discloses PHI, including disciplinary procedure;

(l) To notify you following any breach of unsecured PHI;

(m) To get your permission for most uses and disclosures of PHI for marketing purposes and sales of PHI; and

(n) Uses and disclosures not described in this Notice will be made only with your authorization.

7.8 Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor. The Plan and the Plan Administrator are permitted to use and disclose PHI for the following purposes to the extent they are not inconsistent with HIPAA:

(a) For general Plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function;

(b) As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan;

(c) Other uses relating to Plan administration that are approved in writing by the Plan Administrator; and

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

7.9 Uses and Disclosures of PHI 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:

(a) Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena;

(b) For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process; and

(c) As otherwise may be required by law.

7.10 Participant's Other Rights under HIPAA. Participants and their covered spouses and dependents will have the rights set forth in the Plan's or its insurer's HIPAA Notice of Privacy Practices for PHI and any other rights and protections required under the HIPAA. The Plan or its insurer may periodically revise the Notice.

7.11 Special Rights Upon Childbirth. Generally, group health plans, like this one, can not restrict any hospital length of stay in connection with childbirth for the mother or the baby to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean delivery. Group health plans can not require that an attending doctor get permission from the plan to keep the mother and baby longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. The attending doctor may consult with the mother and decide to release the mother and baby earlier than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery.

7.12 Notice of COBRA Continuation Coverage Rights. You are receiving this notice because you are covered under a group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.

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The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It may also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review contact the Plan Administrator.

7.13 Covered Participant Rights. You may have a right to choose this continuation coverage if you lose your group health coverage under the COBRA plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

7.14 Covered Spouse's Rights. If you are the spouse of an employee covered by a COBRA plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the COBRA plan for any of the following reasons:

(a) The death of your spouse;

(b) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

(c) Divorce or legal separation from your spouse; or

(d) Your spouse becomes entitled to Medicare.

7.15 Covered Child's Rights. If your dependent child is a Participant in the COBRA plan (including a child born or placed for adoption with you during the COBRA continuation period), your child has the right to continuation coverage if group health coverage under the COBRA plan is lost for any of the following reasons:

(a) The death of a parent;

(b) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;

(c) Parents' divorce or legal separation;

(d) A parent becomes entitled to Medicare; or

(e) The dependent ceases to be a "dependent child" under the Plan.

7.16 When is COBRA Available? When the Employer is notified that an event triggering COBRA has happened, the Employer, will notify you that you have the right to choose continuation coverage. Under the law, you have at least sixty (60) days from the date you would lose coverage because of one of the events described above to inform the Employer that you want continuation coverage.

Under the law, you or your family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under a COBRA plan. Notice must be given to the Employer within sixty (60) days of the happening of the event.

If you fail to provide proper notice to the Plan Administrator within sixty (60) days, you may lose COBRA coverage. If you do not choose continuation coverage, your group health coverage will end.

If you fail to provide proper notice to the Plan Administrator within sixty (60) days, you may lose COBRA coverage. If you do not choose continuation coverage, your group health coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the COBRA plan to similarly situated employees or family members. This means that, if the coverage for similarly situated employees or

family members is modified, your coverage will be modified.

7.17 How Long Do I Have Coverage Under COBRA? You are eligible to continue coverage for no more than eighteen (18) months after termination of your employment or thirty-six (36) months after any other qualifying event. If you or a family member is disabled at the time of your termination or reduction in hours, or you or a family member becomes disabled during the first sixty (60) days of COBRA coverage, the continuation coverage period is twenty-nine (29) months.

(a) The Social Security Administration must determine if the disability is a qualified disability that extends the continuation coverage period under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. Such determination must be made within the first eighteen (18) months of COBRA continuation coverage.

(b) For the twenty-nine (29) month continuation coverage period to apply, you or your family member must notify the Employer within sixty (60) days of the determination of disability under the Social Security Act and within the first eighteen (18) months of COBRA continuation coverage.

If a second qualifying event occurs within eighteen (18) months after a termination or reduction in hours, you have three (3) years of continuing coverage from the date of the original qualifying event. If you or a family member have a twenty-nine (29) month continuation period by reason of a disability, as described above, and another qualifying event (other than bankruptcy) occurs within the twenty-nine (29) month continuation period, then the continuation coverage period is thirty-six (36) months from the termination of employment or reduction in hours.

The law provides that your continuation coverage may be cut short for any of the following reasons:

(a) The Employer no longer provides group health coverage to any of its employees,

(b) The premium for coverage is not paid on time,

(c) The qualified beneficiary becomes covered under another group health, unless that plan limits or excludes a preexisting condition,

(d) The qualified beneficiary becomes entitled to Medicare benefits,

(e) The qualified beneficiary ceases to be disabled if covered under the twenty-nine (29) month extension for disability, or

(f) The normal time period for which continuation coverage must be allowed expires.

7.18 How Much Does COBRA Cost? You do not have to show that you are insurable to choose continuation coverage. However, if you elect continuation coverage, you will be required to pay the entire cost of the continued coverage. In addition, the Employer is entitled to add a 2% surcharge to each

monthly premium to help cover the administrative expenses. Therefore, you may be charged a total of 102% of the premium.

The Employer may charge you 150% of the appropriate premium from the nineteenth (19th) through the twenty-ninth (29th) month of disability extension.

7.19 COBRA Questions. This law applies to the plan(s) listed as COBRA plans. If you have any questions about the law, please contact the Employer.

If you have changed marital status, or you or your spouse has changed addresses, please notify the Employer at the above address.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified within this document. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health and welfare plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

7.20 Keep Your Plan Informed of Address Changes. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

7.21 Women's Health and Cancer Rights Act of 1998 Notice. On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member, elect breast reconstruction in connection with a mastectomy you also will be covered for:

(a) All stages of reconstruction of the breast on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and co-insurance established for other benefits under your plan also apply to these reconstructive surgery benefits.

7.22 Patient Protection and Affordable Care Act (PPACA). The Patient Protection and Affordable Care Act was passed on March 23, 2010.

Effective January 1, 2011, if a Underlying Group Benefit Plan covers your dependent children, such children

may continue to be covered through age 26. This provision does not necessarily apply to limited scope plans such as dental and vision plans.

Effective January 1, 2011, the Plan may no longer reimburse you for over-the-counter drugs (other than insulin). Only prescriptions ordered by a physician may be reimbursed by the Plan.

Effective January 1, 2011, if you are a reservist in the United States military, and are called to active duty for a period of at least 180 days, you may be entitled to Plan benefits before beginning your duty. See the Plan Administrator for details.

A group health plan that existed before March 23, 2010, is a grandfathered plan. Changes in any of the following may cause a group to lose the "grandfathered" status and thus will have to comply with certain changes: change of insurance carrier, the elimination of benefits to diagnose or treat a condition, increase of cost-sharing, and a significant increase in deductible and/or co-payments.

A pre-existing condition exclusion is a limitation or exclusion of group health benefits, including a denial of coverage, based on the fact that a condition was present before the effective date of coverage. A provision of PPACA eliminates this exclusion. For Participants under age 19, the provision is effective for plan years beginning on or after September 23, 2010 (or January 1, 2011 for calendar year plans). The provision is extended to all Plan participants for plan years beginning on or after January 1, 2014.

7.23 Special Enrollment Rights.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance of group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if your or your dependents lose eligibility for that other coverage (of if the employer stops contributing toward your or your dependent's other coverage). You must request enrollment within 31 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

Also, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the Plan. You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

The plan also will allow a special enrollment opportunity if you or your eligible dependents either: lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days - instead of 31 - from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

To request special enrollment or to lean more, contact the Plan Administrator. Note that you will be required to submit documentation related to the special enrollment event.

PART 8
OTHER INFORMATION

8.1 No Contract of Employment. The Plan is not intended to be, and may not be taken as a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time. Neither the maintenance of this Plan or anything contained in the Plan shall be taken as giving you any equity nor other interests in the assets, business, or affairs of the Plan Administrator, Employer or Plan Sponsor except as specifically provided for in any applicable Plan documents.

8.2 No Guarantee of Tax Consequences. Neither the Employer nor the Administrator make any guarantee that any amounts paid to or for your benefits under the Plan will be excludable from your gross income for Federal, state or local income tax purposes, or that any other Federal, state or local tax treatment will apply to or be available to you.

8.3 What If I Need More Information? This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan at the Employer's corporate office at 8960 Springbrook Drive, Suite 150, Coon Rapids, MN 55433 or by contacting the Plan Administrator at any time during regular working hours. There may be a charge for the expense of copying the Plan document.

Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan shall control.

Certain information concerning the Plan may be filed with the Treasury Department and the Department of Labor. Should you wish to talk to either agency about this Plan, you must refer to the Employer's Tax Identification Number and Plan Number, both of which are found in the beginning of this document.

The Plan Administrator has been designated as agent for purpose of service of legal process. The address of the Plan Administrator is the same as the Employer's address and is listed at the beginning of this document.

ATTACHMENT A

Medical - Fully-Insured

ATTACHMENT B

Dental - Self-Insured

ATTACHMENT C

Vision - Fully-Insured

ATTACHMENT D

Long Term Disability - Fully-Insured

ATTACHMENT E

Short Term Disability - Fully-Insured

ATTACHMENT F

Life Insurance - Fully-Insured

ATTACHMENT G

Voluntary Life for Employees and Dependents - Fully-Insured

ATTACHMENT H

Cafeteria Plan - Fully-Insured