Health Reimbursement Arrangement (HRA)
Summary Plan Description

As Adopted By Employer:

GRANDE CHEESE COMPANY

Plan Information

Plan Sponsor, Plan Administrator and Agent for Legal Process:	GRANDE CHEESE COMPANY
Claims Administrator:	eflexgroup.com 2740 Ski Lane Madison, WI 53713 877-933-3539 www.eflexgroup.com
Plan Year:	JANUARY 1ST – DECEMBER31ST
Employer EIN:	39-0897071
Plan Number:	501
Plan Type:	Health Reimbursement Arrangement (HRA) described in Section 105 of the Code.
Type of Administration:	This is a self-funded plan, administered by the Plan Administrator. The Plan also has a Claims Administrator that provides professional claims processing services
Plan Funding:	Employer Credits are allocated to pay Benefits from the Employer's general assets. Employees make no contributions.
QMCSO Procedures:	The Plan's procedures for a Qualified Medical Child Support Order ("QMCSO") are available from the Plan Administrator.

If you have questions about the Plan, you may contact the Plan Administrator.

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Introduction

This Summary Plan Description ("Summary") explains the main provisions of the Plan. **Please read it carefully**. It is important to understand the Plan requirements and the Benefits it can provide for you and your family. If you have any questions after reading the Summary, please contact the Plan Administrator.

The Plan is a complex legal document. This Summary is intended to serve as an easy-to-read explanation of the Plan. Although every effort has been made to make this Summary as accurate as possible, the Summary is not a substitute for the Plan document. The detailed provisions of the Plan, not this Summary, govern the actual rights and benefits to which you are or may be or become entitled.

Purpose

1. What type of Plan is this Plan?

This Plan is intended to qualify as a Health Reimbursement Arrangement (HRA) described in section 105 of the Internal Revenue Code with benefits paid by your Employer.

2. What is the purpose of this Plan?

The purpose of this Plan is to provide reimbursement for certain Qualifying Medical Expenses incurred by Plan Participants and/or their Dependents.

Eligibility, Enrollment and Participation

1. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you meet the following requirements for participation:

Employees must be enrolled in the Group Major Medical.
Employees who are classified as full time and work at least 40 hours per week.
Retirees with the company will be allowed to continue to use their HRA funds on eligible health care expenses until the account is depleted, regardless if they choose COBRA medical benefits or not. Any Grande Associate that is termed from the company and elects COBRA medical must have their HRA account remain active as they are eligible to continue to use their HRA funds.

Workers who are classified by the Employer as independent contractors, leased employees, contract workers, temporary employees or seasonal or casual employees are not eligible for Benefits under the Plan. Individuals who are self-employed such as sole proprietors, outside directors, partners or more than 2% shareholders of a S-Corporation are not eligible to participate in the Plan.

You can permanently opt out of and waive future reimbursements from this HRA Plan at least annually at the annual open enrollment and upon termination of employment. The remaining amounts in the HRA Plan are forfeited. If benefits are provided under this HRA Plan following termination of employment you are permitted to permanently opt out of and waive future reimbursements from this HRA Plan at the time employment is terminated.

2. When am I eligible to participate in the Plan?

You can participate in the Plan as of the following dates: First of the month following two full months of employment

3. How do I elect to participate in the Plan?

Enrollment in the HRA is automatic once eligibility and participation requirements are met.

4. Can I change my election during the Plan Year?

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

5. What happens if I am rehired after terminating employment?

If you are rehired at a later date, you may participate in the Plan if you are eligible.

6. When does my Participation in the Plan end?

Your participation will end if:

- You elect not to participate;
- You no longer satisfy the eligibility requirements for the Plan;
- You terminate employment with Employer (there are special rules for terminating employees); or
- The Plan is terminated or amended to exclude you from eligibility.

Leaves of Absence

1. What happens if I take an unpaid leave that is covered under the Family Medical Leave Act ("FMLA leave")?

If you go on a qualifying unpaid FMLA leave, your Employer's policies and the law will determine your rights to continue coverage during the leave and reinstatement of coverage following the leave.

2. What happens if I take personal leave which is not an FMLA leave?

Your Employer's policies for each type of Employer-approved leave will govern your rights to continue coverage during the leave and reinstatement following the leave.

3. What are my rights to coverage under the Plan while I am on military service leave?

Your right to continue participation in the Plan during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). If you go on a qualifying unpaid military leave, your Employer's policies regarding military leave and the law will determine your rights to continue coverage during the leave and reinstatement of coverage following the leave.

Benefits

1. What Benefits are available from the Plan?

The Plan allows you to use Employer Credits to pay for unreimbursed Qualifying Medical Expenses. Unreimbursed Qualifying Medical Expenses are expenses that are not covered by insurance or other group benefits. You must be the only source of payment for the Qualifying Medical Expenses. Plan design is as follows:

Employer will reimburse employees for all eligible 213d expenses. For a list of eligible 213d expenses please refer to our website www.eflexgroup.com

Single-Employer will reimburse the first $240.00

Limited Family- Employer will reimburse the first $480.00

Family- Employer will reimburse the first $720.00

Qualifying Medical Expenses include amounts incurred for the diagnosis, care, mitigation, treatment or prevention of disease, affecting any structure or function of the body.

Dependent Coverage:

- ✹ Plan includes Qualifying Medical Expenses for dependents. A qualified dependent includes but is not limited to your lawful spouse and child(ren), legally adopted child, child placed for adoption, step-child and foster child. A Dependent also includes a child who is an alternate recipient under a qualified medical child support order.

  Dependent also includes a child of a Participant who has not reached his or her 26th birthday, provided that such child is not eligible for group health coverage except through the Participant as required by PPACA and may continue beyond that date for a child who is physically or mentally disabled. You can contact the Claims Administrator with specific questions about Dependent eligibility.

- ❑ Plan provides coverage for employee only; there is no coverage for dependents.

2. During what period are Qualifying Medical Expenses I incur reimbursable?

You may seek reimbursement for Qualifying Medical Expenses incurred while you are covered by the Plan provided that you file your claim on a timely basis.

3. When is a Qualifying Medical Expense "incurred"?

A Qualifying Medical Expense is incurred when the Medical Care is provided, not when you are formally billed, charged or pay the expense. You cannot receive reimbursement for future or projected expenses.

4. How does participation in a Health Savings Account (HSA) impact my ability to receive Benefits?

In the event you are enrolled in a qualifying high deductible health plan, you may not receive reimbursement for any Qualifying Medical Expense until you have satisfied the minimum deductible of your high deductible health plan. This means that your Benefits from the Plan will be unavailable for reimbursement of any expenses that fall within the applicable deductible. There are some limited exceptions. One exception to this rule is that you may receive reimbursement for Qualifying Medical Expenses for preventative care, if such care is otherwise covered under the terms of this Plan.

5. How does participation in a flexible spending account (FSA) impact my ability to receive Benefits?

In the event your Qualifying Medical Expenses are covered by both this Plan and an FSA, then you may seek reimbursement in the following order:

FSA pays first

6. Can I "carry over" unspent funds?

The Plan's rules regarding carry-over of unspent funds are as follows:

100% Rollover.

Rollover is completed after the 90 day end of year grace period has ended. Rollover funds then become the current year dollars and can only be used for expenses incurred within that year. Once Rollover has been completed, expenses from the prior year will be denied. Maximum rollover is $5000.00

Making Claims For Benefits

1. How do I submit a claim for reimbursement?

You will be reimbursed for your eligible uninsured Qualifying Medical Expenses by submitting your completed claim form to the Claims Administrator. Your claim for Benefits must include:

- The amount and date of each expense;
- The name of the person, organization or company to which the expense was paid;
- The name of the person for whom the expense was incurred and, if that person is not the Participant in the Plan, the relationship of the person to the Participant;
- The amount recovered or expected to be recovered for that expense under any insurance arrangement or other plan;
- A statement that the expense (or the portion of the expense for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage. If the expense is insurable, the Participant must provide an explanation of benefits ("EOB");
- Any bills, invoices, receipts, canceled checks or other statements showing the amount of the expense; and
- Any other information required by the Claims Administrator.

2. What rules apply if I submit claims for reimbursement through a debit card?

If your plan allows the use of a debit or stored card for payment of Qualifying Medical Expenses, you must comply with the rules for the card established by the Claims Administrator, including the following rules:

- You must enter into a written agreement to certify:
  - -- that your card will only be used for Qualifying Medical Expenses that have been incurred within the applicable plan year;
  - -- that any Qualifying Medical Expense you pay with the card will not have been already reimbursed by any other plan covering health benefits;
  - -- that the you will not seek reimbursement from any other plan covering health benefits; and
  - -- that you will obtain and maintain sufficient documentation for Qualifying Medical Expenses you pay with the card.
- A card will only be issued to you upon your participation in the Plan. The card will be automatically cancelled upon your death or termination of employment, if you are no longer enrolled in the Plan or you withdraw due to a change in status, or if you use the card for impermissible expenses.
- The dollar amount of coverage available on the card is the amount available under the Plan.
- Use of the card is limited to medical care providers and certain stores allowed under IRS guidance for card payments of Qualifying Medical Expenses.
- Your use of the card for Qualifying Medical Expenses is subject to substantiation to the Claims Administrator, usually by submission of a receipt from a medical provider or certain stores describing the product or service, the date and the amount. All charges are conditional pending confirmation and substantiation. Submission of receipts for card payments is not required for Qualifying Medical Expenses that are substantiated copayment matches, certain recurring Qualifying Medical Expenses, real-time substantiation of Qualifying Medical Expenses at the time of sale and Qualifying Medical Expenses substantiated through an inventory information approval system if the IRS requirements for these types of substantiations are satisfied.
- If you fail to provide the Claims Administrator with requested substantiation for a Qualifying Medical Expense or if your card purchase is later determined by the Claims Administrator to not qualify as a Qualifying Medical Expense, the Claims Administrator and/or Employer, in its discretion, will use one or more of the following correction methods to make the Plan whole:
  - -- deactivate the card until the amount of the improper payment is recovered;
  - -- require you to repay the improper amount;
  - -- if you fail to repay the improper amount, withhold the improper payment from your wages or other compensation to the extent permitted by applicable federal or state law;
  - -- if the amount remains unpaid, offset future claims until the amount is repaid; and
  - -- if the amount continues to remain unpaid, treat the improper payment as a debt you owe to the Employer.

3. What is the deadline for submitting claims for reimbursement?

You must submit all claims for reimbursement within:

✹ 90 days from the end of the Plan Year in which they are incurred.

❑ _____ days from the end of the Plan Year in which they are incurred.

No claims submitted after time period above will be reimbursed. If you terminate from the plan prior to end of the year, you will have: ✹ 90 days ❑ _____ days from date of termination to submit for claims incurred on or prior to your termination date. No claims submitted after that time will be reimbursed.

4. When will I find out if my claim for Benefits has been approved or denied?

The Plan Administrator will notify you within 30 days from the date your claim was received if it has been approved, denied, or if additional information is required. The 30-day period can be extended to 45 days under certain circumstances.

If the Plan Administrator requests more information, you will be given at least 45 days from the date of notice to provide the specific information. If you submit the additional information within the 45-day (or longer) period, the Plan Administrator will notify you of the claims determination within 15 days from the date the Plan Administrator received the additional information.

5. What happens if my claim for Benefits is denied?

If your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

- The reason(s) why the claim or a portion of it was denied;
- Reference to Plan provisions on which the denial was based;
- If the denial was based on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol. The information will be provided free of charge;
- What additional information, if any, is required to perfect the claim and why the information is necessary; and
- What steps you may take if you wish to appeal the decision, and a statement that after you follow the Plan's internal review process for your appeal, you may file an action in federal court under Section 502 of ERISA, if you disagree with the Plan's decision on the appeal.

6. How do I appeal a denial of Benefits?

If you dispute a denial of benefits, you may file an appeal within 180 days of receipt of the denial notice. This appeal must be in writing and must contain the following information:

- Your name and address;
- Your reasons for making the appeal; and
- The facts supporting your appeal.

The appeal will be answered in writing within 60 days, stating whether it has been granted or denied. The claim review will be subject to the following rules:

- The claim will be reviewed by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial denial nor a subordinate of that individual.
- The review will be conducted without giving deference to the initial denial.

7. What happens if my appeal is denied?

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

- The specific reasons for the appeal denial.
- Reference to the specific Plan provisions on which the denial is based.
- A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits. The information will be provided to you without charge.
- If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol. The information will be provided to you without charge.
- A statement regarding your right to bring an action under Section 502(a) of ERISA.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described under these claims procedures. If any of the claims procedures outlined above are not followed, you will be deemed to have exhausted the opportunities described under these procedures and may pursue legal action at any time. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, you are not satisfied with the result, then you must file any legal action within 180 days of receiving the final review notice under these procedures.

8. Do additional rules and rights apply?

The following additional requirements apply to the Plan:

- A rescission of coverage will be treated as a claim denial and subject to all of the rules and requirements of a claim denial;

- Written or electronic notices to you must be provided in a culturally and linguistically appropriate manner as required by the Affordable Care Act;

- Notice of a claim denial must also include information sufficient to identify the claim involved, any denial codes and their corresponding meaning, the standard used in denying the claim, what steps you may take for external appeal of the decision and the availability of and contact information for, an applicable office of health insurance customer assistance or ombudsman;

- In the event you submit a claims appeal, you will be permitted to present evidence or testimony relating to the claim;

- In the event the Administrator relies on, considers or generates new additional evidence relevant to a claim, the Administrator must provide you with that information, free of charge, sufficiently in advance of the due date of the notice of final adverse benefit determination to give you reasonable opportunity to respond. If a final adverse benefit determination is based on new or additional rationale, the Administrator must provide you the rationale sufficiently in advance of the due date of the notice of final adverse benefit determination to give you a reasonable opportunity to respond;

- The Administrator must ensure that all claims are adjudicated in a manner to ensure the independence and impartiality of the persons involved in making the decision.

You may file a request for external review with the Administrator, provided that the request is filed within four months after the date of receipt of final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of the notice, the request must be filed by the first day of the fifth month following receipt of notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next business day.

Within five business days following the date of receipt of the external review request, the Administrator will complete a preliminary review of the request to determine whether (1) you are or were covered under the Plan at the time the health care item or service in question was provided; (2) the adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan; (3) you have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process; and (4) you have provided all the information and forms required to process the external review.

Within one day after completion of the preliminary review, the Administrator will issue you a notification in writing. If the request is complete, but not eligible for external review, the notice must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Administrator will allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

In the event the Administrator determines that your request for external review is valid, the Administrator will assign an Independent Review Organization (IRO) that is accredited by URAC or by similarly nationally-recognized crediting organizations to conduct the external review. The Administrator will take action against bias and ensure independence. In this regard, the Administrator will contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support denial of benefits.

The contract between the Plan and the IRO will include the terms that are required by regulations under the Affordable Care Act.

In the event of a notice of final external review decision reversing the adverse benefit determination, the Plan will provide immediate authorization for payment of the claim.

Continuation under Cobra

1. What are my COBRA rights?

The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") is a federal law which allows you or your Dependents to continue coverage under a group health care plan after a "qualifying event" occurs:

- A qualifying event is an event which would cause you or your Dependent to lose health care coverage under the terms of the Plan.
- Qualifying events may include your death, your termination of employment or reduction of hours, your divorce or legal separation, your entitlement to Medicare, or a Dependent child's loss of Dependent status.

You must notify the Employer of a divorce, legal separation or a child losing Dependent status under the Plan within 60 days of the event or the date coverage is lost, whichever is later. For a divorce or legal separation, you must include a copy of the divorce decree or court order. To substantiate a child's loss of Dependent status, you must include proof of age or loss of full-time student status or other applicable documentation. You have 60 days from the date you would lose coverage for one of the reasons listed above or the date you are sent a notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage.

2. How does COBRA apply to the Plan?

This Plan qualifies as a group health plan and COBRA rules regarding continuation of coverage apply. Under the COBRA regulations, you may be eligible to continue coverage for up to 18 to 36 months depending on the qualifying event. The Plan Administrator will tell you how long you may continue coverage under COBRA and will provide you a COBRA Election Form. You may elect COBRA coverage as provided on the Form.

3. How much am I required to pay for COBRA coverage?

The cost is the cost of the coverage plus a 2% administrative charge.

ERISA Rights

Plan Participants who are entitled to certain rights and protections pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Employer and Plan Administrator intend to comply fully with ERISA. If you have a question about the Plan, how it is run and how it affects you, you should contact the Plan Administrator.

Receive Information About Your Plan and Benefits

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 worksites and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the 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, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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 concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

Notice

Although the Plan provides only reimbursement for Qualifying Medical Expenses, the following notices are included to ensure compliance with federal law:

> "Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain

authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."

The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting a mastectomy, including lymphedema.

Assistance With Your Questions

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.