Your Premium Conversion Plan—A Brief Description

Park Pro has established a Section 125 Premium Conversion Plan, which lets you pay for certain premium expenses listed in Schedule A with pre-tax dollars. IRS allowable premium expenses include:

Employer sponsored group health, dental, vision, employee-only group term life (up to $50,000 death benefit), disability, accident, cancer and intensive care insurance plans.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

What is the Premium Conversion Plan and how does it work?

The Premium Conversion Plan is set up under Section 125 of the Internal Revenue Code and provides you with a tax benefit. This is how it works: A portion of your pay is withheld by Park Pro for the purpose of paying your share of your medical premium. The money withheld for premiums is not subject to federal income, Medicare, or Social Security (FICA) taxes, and in most cases, state and local taxes. Accordingly, you will save on most federal, state, and local taxes (the exact savings depends upon your tax bracket and your state of residence). Here's an example:

Let's say you earn $36,000 per year, and pay $250 a month in insurance premiums. Your estimated take-home pay would be $1,980.50 per month after taxes and premiums are withheld. With a Section 125 Premium Only Plan, you pay qualified insurance premiums with pre-tax dollars. In this example, your take home pay would be $2044.63 an increase of $64.13 per month or $769.56 a year.

Paycheck	After Tax	125 Pre Tax
Monthly Income	$3,000.00	$3,000.00
Insurance Premiums	$0.00	($250.00)
Taxable Pay	$3,000.00	2,750.00
Federal Income Tax (15%)	($450.00)	($412.50)
Social Security Tax (7.65%)	($229.50)	($210.38)
State Tax (3%)	($90.00)	($82.50)
Pay After Taxes	$2,230.50	$2,044.63
Insurance Premiums	($250.00)	$0.00
Take-home Pay	$1,980.50	$2,044.63
Monthly Savings		**$64.13**
Annual Savings		**$769.56**

Am I eligible to participate?

You are eligible to participate in the Premium Conversion Plan if you are an employee regularly scheduled to work 32 or more hours per week for Park Pro ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts listed in Section A. You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the
Park Pro.

Your spouse, domestic partner, or dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your spouse or dependent(s) cannot participate in the Plan independently.

You are not eligible to participate in the plan if you are:

A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

Covered by a collective bargaining agreement.

A leased employee.

A non-resident alien who received no U.S. earned income.

A part-time employee who is expected to work less than 32 hours per week

How do I enroll?

To enroll in the Plan, you must complete an election form; thereafter, you only need to complete an election form if you are making an election change. For the purposes of this Plan, "Plan Year" means the twelve-month period commencing December 1st and ending on the subsequent November 30th. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections, see "Election Changes" in this Summary. If for any reason you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the new Plan Year.

Can I choose not to participate in the Premium Conversion Plan?

Yes. To opt-out of the Premium Conversion Plan, you need to complete a written waiver/election form and return it to Park Pro Plan Administrator. If you do not pay federal income tax, you should consider waiving participation in the Premium Conversion Plan.

How does participation in the Premium Conversion Plan affect my other benefits, such as Social Security?

Participating in the Premium Conversion Plan could slightly lower your Social Security benefit. This is because your Social Security benefit is calculated based on your taxable earnings. Participating in the Premium Conversion Plan will reduce your taxable earnings and accordingly affect your Social Security benefit calculation. You may experience a similar effect on other benefits such as life insurance, disability, or pension benefits, depending upon how these other benefits define compensation. If these benefits, like Social Security, are calculated based on your taxable earnings, your participation in the Premium Conversion Plan could result in lower benefits.

May I change my Premium Conversion Plan participation?

Each year, we will have an open enrollment period during which you may change your participation to the Premium Conversion Plan. During open enrollment, you may elect to participate if you haven't been doing so, you may cancel your participation, or you may make a change to your election—such as increasing your participation level to add a dependent to your medical coverage.

Except for annual open enrollment, you cannot change your Premium Conversion Plan participation unless you experience a "qualifying change in status" as defined by the Internal Revenue Service. If you experience a change in status, you may only change your participation status within 30 days of the event and your requested change must be consistent with the change in status that you experience.

The following is a list of changes in status that may allow you to make a change to your elections.

Legal marital status: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.

Number of eligible dependents: Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption.

Employment status: Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:

Beginning or ending employment;

Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

Changing from part-time to full-time employment or vice versa

Dependent status: Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances.

Residence: A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area.

Loss of Other Coverage: If you decline enrollment for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Premium Conversion Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage);

Change in Cost: If the cost charged to you for your Medical Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits.

Change in Coverage: You may also change your election if one of the following events occurs: *Significant Curtailment of Coverage.* If your Medical Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.(The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage).

Change in Election under another Employer Plan: You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.

Eligibility for Premium Assistance Subsidy: Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy.

Certain Judgments, Decrees, and Orders: If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

Government coverage: If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs.

Enrollment in Health Insurance Marketplace: You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.)

FMLA Leaves of Absence (Applicable to groups of 50+ employees)

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be

available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

What happens if I take a leave of absence or terminate employment?

If you take a leave of absence, you may be able to revoke your election. See your employer about information about your rights. If you stop working for your employer, whatever the reason, your participation in the Premium Conversion Plan will automatically terminate. This means that any premiums for medical coverage after you stop working must be paid with after-tax dollars.

COBRA Continuation Coverage (Applicable groups of 20+ employees)

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.

Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

"Medicare'" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

ERISA Rights

The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to help assure that all employer-sponsored group Medical Insurance Benefits conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA which provides that all Participants will be entitled to (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, if any, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report {generally only applicable to Health FSA plans and employer sponsored self-funded health and welfare benefit plans with more than 100 participants that are required to file a Form 5500 annual report). Plan records are kept on a Plan Year basis.

In addition to creating rights for plan participants, ERISA imposes duties upon those responsible for the operation of a plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Within 180 days of receipt of a notice denying a claim you or your duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator, or by an appeals committee appointed by the Employer for that purpose ("Committee"). The Plan Administrator may extend the 180-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate.

Under ERISA, there are steps an Employee covered under a plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay

the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the company's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If the plan fiduciaries misuse the Plan's money, or if an Employee covered under this Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Plan Administrator of Park Pro. If an Employee has any questions about this statement of the Employee's rights under ERISA, the Employee should contact the nearest Area office of the U.S. Labor-Management Services Administration, Department of Labor.

Special Note: This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect by your Employer's Premium Only Plan document, a copy of which is available from the company upon your request (see Statement of ERISA Rights). If there is any discrepancy between the descriptions of the Plan as contained in this material and the official Plan document, the language of the Plan document shall govern.

Plan Sponsor and Administrator

The Plan is sponsored by Park Pro 5002 E Taylor St Phoenix AZ 85008. Park Pro also acts as Plan Administrator. The Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries.

Plan Identification Numbers

The Employer Identification Number ("EIN") assigned to Employer by the Internal Revenue Service ("IRS") is 86-0352407. The Plan Number ("PN") assigned to the Premium Only Plan by the Company is 501. You should refer to these numbers in any correspondence about the Plan.

Park Pro

Schedule A

COVERAGE OPTIONS UNDER THE PLAN

Medical

Dental

Vision