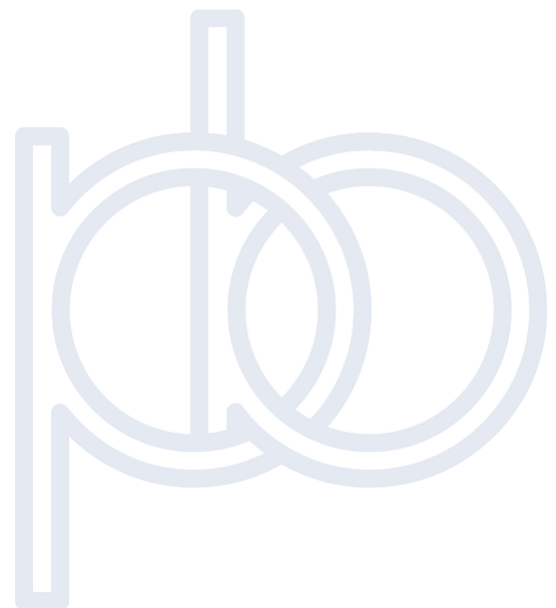


FLEXIBLE SPENDING ACCOUNT PLAN
FOR UNITED CHURCH OF CHRIST MINISTRIES
SUMMARY PLAN DESCRIPTION
(revised January 2007)



Table of Contents

2	Introduction
3	I. Eligibility
3	1. When Can I Become a Participant in the Plan?
3	2. What Are the Eligibility Requirements for Our Plan?
3	3. What Is My Entry Date?
3	4. What Must I Do to Enroll in the Plan?
3	II. Operation
3	1. How Does This Plan Operate?
4	III. Contributions
4	1. How Much of My Pay May the Employer Redirect?
4	2. What Happens to Contributions Made to the Plan?
4	3. When Must I Decide Which Accounts I Want to Use?
4	4. When Is the Election Period for Our Plan?
4	5. May I Change My Elections During the Plan Year?
5	6. May I Make New Elections in Future Plan Years?
5	IV. Benefits
5	1. What Benefits Are Available?
7	V. Benefit Payments
7	1. When Will I Receive Payments from My Accounts?
7	2. What Happens If I Don't Spend All Plan Contributions?
7	3. Family and Medical Leave Act (FMLA)
7	4. Uniformed Services Employment and Re-employment Rights Act (USERRA)
8	5. What Happens If I Terminate Employment?
8	6. Will My Social Security Benefits Be Affected?
9	VI. Plan Accounting
9	1. Periodic Statements
9	VII. General Information About Our Plan
9	1. General Plan Information
9	2. Sponsor Information
9	3. Plan Administrator Information
10	4. Service of Legal Process
10	5. Type of Administration
10	6. Claims Submission
10	VIII. Additional Plan Information
10	1. Claims Process
12	IX. Summary
13	Appendix
	Qualifying Medical Care Expenses



Introduction

The Flexible Spending Account (FSA) Plan was established for you and other eligible employees. Under this program, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

There are two parts to your FSA Plan:

- The Health Care Reimbursement Account that will help with expenses related to medical, dental and vision care.
- The Dependent Care Assistance Account which will help with work-related dependent day care costs.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a Plan document on file which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will take precedence.



I. Eligibility

1. When Can I Become a Participant in the Plan?

Before you become a participant in the Plan, there are certain rules which you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the entry date that we have established for all employees. You also will be required to complete certain application forms before you can enroll in the Plan.

2. What Are the Eligibility Requirements for Our Plan?

If you are currently employed, you can only enroll during the open enrollment period at the end of each year for an effective date of coverage of January 1 of the following year. New employees are eligible to enroll on the first of the month after their date of employment.

3. When Is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. What Must I Do to Enroll in the Plan?

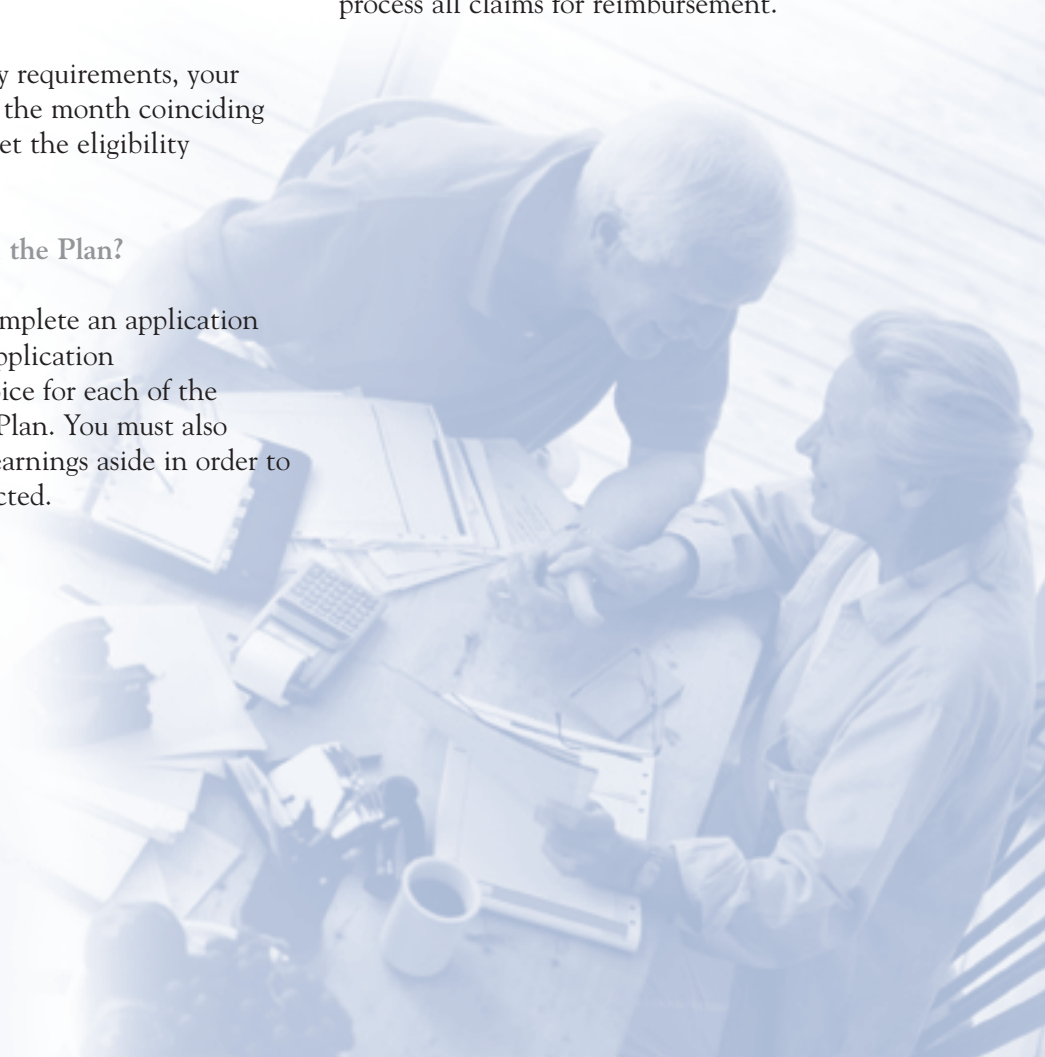
Before you can join, you must complete an application to participate in the Plan. The application should include your personal choice for each of the benefits being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II. Operation

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts, which must be set up for you, in order to withhold salary for the benefits you have chosen. The portion of your salary that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return for that expense.

The Pension Boards-UCC has made a special arrangement with the firm of National Associates in Cleveland, Ohio to assist with administration and to process all claims for reimbursement.



III. Contributions

1. How Much of My Pay May the Employer Redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. The maximum that can be deferred to the FSA for each calendar year is \$3,000 to the Health Care Account and \$5,000 to the Dependent Care Account.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the account(s) you want and how much of the contributions should go toward each account. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. (See the section entitled “General Information About Our Plan,” found on page 9, for the definition of Plan Year.) Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

Federal law requires that during the election period, before the Plan Year begins, you decide on the benefits you want and how much you would like to contribute to each account.

4. When Is the Election Period for Our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your entry date. (You should review Section I on Eligibility to better understand the terms “eligibility requirements” and “entry date.”) Then, for each following Plan Year, the election period will be the 31-day period prior to the beginning of each Plan Year.

5. May I Change My Elections During the Plan Year?

Generally, after the beginning of the Plan Year you cannot change the elections you have made. However, there are certain limited situations when election changes are allowed. You are permitted to change elections if you have a change in status and you make an election change that is consistent with the change in status.

Currently, Federal law considers the following events to be “changes in status”:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent;
- 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;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status or any similar circumstance; and
- A change in the place of residence for you, your spouse or dependent.

In addition, if you are participating in the Dependent Care Account, there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

If the cost of dependent care increases during the year, you may change your elections; however, you may not change your election under the Dependent Care Assistance Account if the cost change is imposed by a dependent care provider who is your relative.

6. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. ***If you do not make new elections during the “election period” before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.***

IV. Benefits

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Account:

The Health Care Reimbursement Account enables you to pay for expenses that are not covered by our medical plan and save taxes at the same time. The account allows you to be reimbursed by the employer for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses that qualify are those permitted by Section 213 of the Internal Revenue Code. A list of covered expenses is available on page 13 of this booklet.

The maximum that you can contribute to your Health Care Reimbursement Account each calendar Plan Year is \$3,000. In order to be reimbursed for a health care expense, you must submit to the Administrator a copy of your health plan Explanation of Benefits (EOB) showing the amounts not paid, or an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

Note: Since federal law does not recognize domestic partnership, you can only receive reimbursement for your domestic partner’s medical expenses if you claim your domestic partner as a dependent for federal income tax purposes.

Dependent Care Assistance Account:

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

Dependent Care arrangements that qualify include:

- A dependent (day) care center, provided that, if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of:

- (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns);
- (b) your taxable compensation;
- (c) your spouse’s actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as

proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for, even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser to find out which is better for you.

V. Benefit Payments

1. When Will I Receive Payments from My Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are not subject to Federal income tax or withholding, nor are they subject to Social Security taxes. Reimbursement for medical expenses is limited to the annual amount you elect. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the account to cover your request. Reimbursement checks are mailed directly to the participant’s address.

2. What Happens If I Don’t Spend All Plan Contributions?

Until recently, the Internal Revenue Service required that if the participant incurred expenses during a Plan Year that were less than the amounts contributed to the Section 125 Plan, the unused contributions were forfeited. However, in May 2005, the IRS relaxed this rule by allowing an additional 2 1/2 month “grace period” following the year. This is great news for anyone participating in the UCC FSA Plan because now a participant has through March 15 of the following year to incur claims before forfeiting FSA dollars.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that you have made, it is important that you decide how much to place in each account carefully and conservatively. *Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins.* You want to be sure that the amount you decide to place in each account will be used up entirely.

Forfeited amounts are used to help pay Plan administration expenses and claims.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Care Reimbursement Account. If your coverage in these benefits terminates due to your revocation of the benefit while on leave, or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Reimbursement Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you were on leave. For example, if you elect \$1,200 for the year and are out on leave for three months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference—from \$100 per month to \$150 per month. Alternatively, your maximum reimburseable amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for three months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Care Reimbursement Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may:

- pre-pay for the coverage
- pay for your coverage on an after-tax basis while on leave
- arrange with your employer a schedule for you to “catch up” on your payments when you return.

4. Uniformed Services Employment and Re-employment 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 Care Reimbursement Account under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask the Administrator for further details.

5. What Happens If I Terminate Employment?

If you leave your employment during the Plan Year, your right to benefits will be determined in the following manner:

- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.
- If your participation in the Health Care Reimbursement Account ceases, you will be able to submit claims for health care expenses incurred prior to your date of termination.

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 Claims Administrator of your death, termination of employment or reduction in hours, the employer's bankruptcy or Medicare eligibility.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because tax-free benefits received under the Flexible Spending Plan reduce the amount of contributions that you make to the Social Security system as well as employer contributions to Social Security on your behalf.



VI. Plan Accounting

1. Periodic Statements

The Administrator will periodically provide you with a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to claim all the money you have designated for a particular benefit by March 15 following the Plan Year.

VII. General Information About Our Plan

This Section contains some general information about the Plan that you need to know.

1. General Plan Information

Flexible Spending Account Plan for United Church of Christ Ministries is the name of the Plan. Your employer has been assigned Plan Number 501 for your Plan.

The provisions of the Plan became effective as designated when we adopted the Plan, but no earlier than April 1, 2005, which is called the Effective Date of the Plan.

Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31, except for the first Plan Year, which began when the Plan was adopted.

2. Sponsor Information

The Pension Boards' name, address, and identification number are:

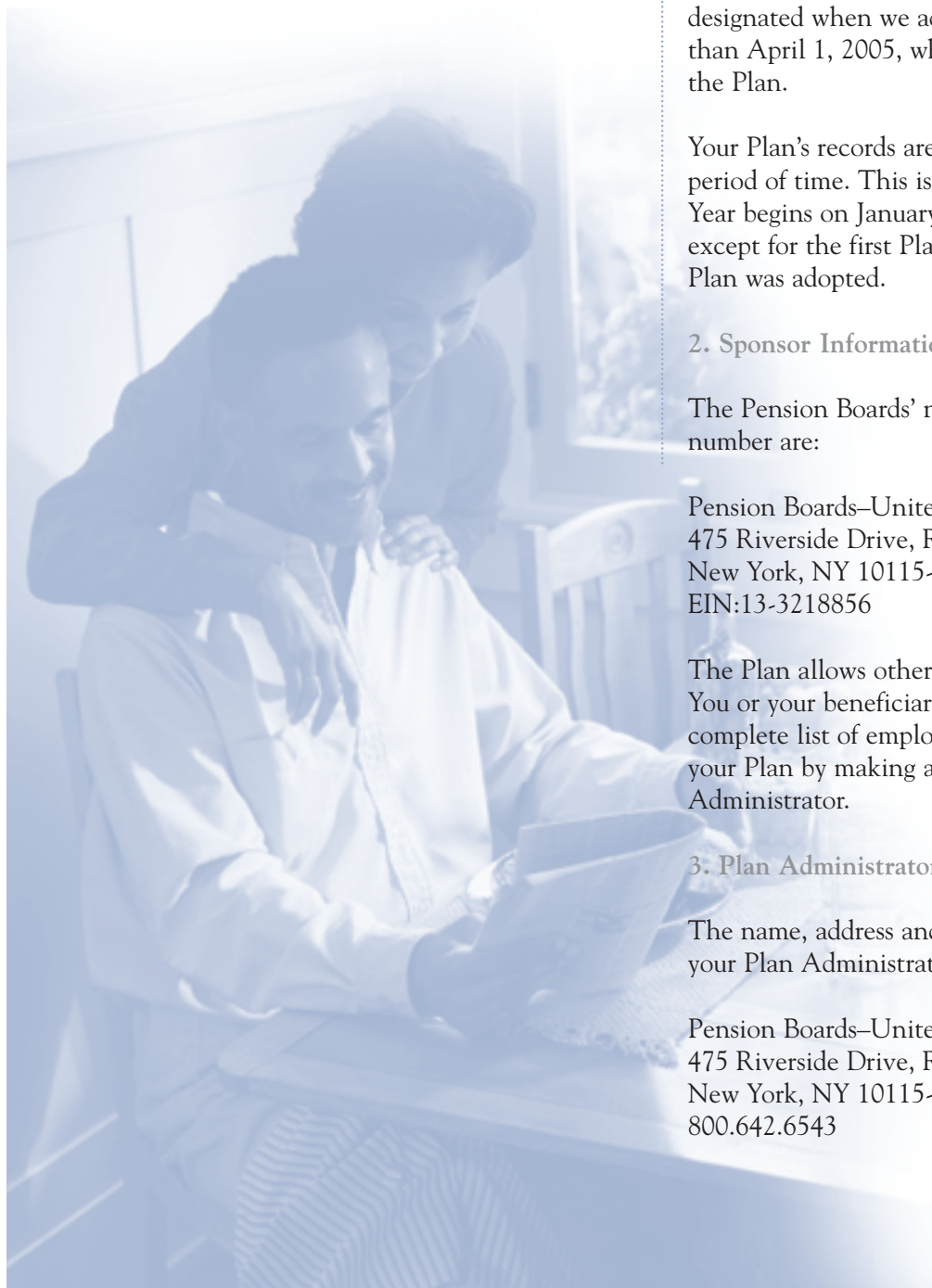
Pension Boards—United Church of Christ
475 Riverside Drive, Room 1020
New York, NY 10115-0059
EIN:13-3218856

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

3. Plan Administrator Information

The name, address and business telephone number of your Plan Administrator are:

Pension Boards—United Church of Christ
475 Riverside Drive, Room 1020
New York, NY 10115-0059
800.642.6543



The Administrator keeps the records for the Plan and is responsible for its administration. Therefore, please feel free to contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Pension Boards—United Church of Christ
475 Riverside Drive, Room 1020
New York, NY 10115-0059

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:
National Associates, Inc.
20325 Center Ridge Road
Cleveland, OH 44116
Fax: 440.333.0221

VIII. Additional Plan Information

1. Claims Process

Expenses incurred during the Plan Year (January 1 through December 31) may be submitted for reimbursement throughout the year. Expenses that you incur through March 15 of the following year may also be deemed as having been incurred during the previous Plan Year. This time after the end of the Plan Year is known as the "grace period." In order to be eligible for reimbursement of any expenses for a given Plan Year (including the grace period), you must submit your claim within 180 days after the March 15 on which the grace period ends. Any claims submitted after that time will not be considered for reimbursement. This provision will be in effect for all Plan Years.

If a claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

- the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based
- a description of any additional information needed to process the claim
- an explanation of the claims

If you fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If requested, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The time period within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record or other information shall be considered relevant to a claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

IX. Summary

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our Flexible Spending Account will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Qualifying Medical Care Expenses

Qualifying medical expenses include only those expenses incurred for:

1. Yourself.
2. Your spouse.
3. All dependents you list on your Federal tax return.
4. Any person that you could have listed as a dependent on your return if that person has not received \$2,450 or more of gross income or has not filed a joint return. This amount is adjusted each year for cost of living.

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your Federal income tax return (without regard to the 7.5% of adjusted gross income limitation). IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this Plan, and those that cannot. However, regardless of any statements in Publication 502 to the contrary, expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged or when you pay for the medical care.

Qualifying medical expenses include expenses you have incurred for:

1. Medicine, drugs, birth control pills and vaccines that your doctor prescribed.
2. Medical doctors, dentists, eye doctors, orthodontists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
3. Medical examination, X-ray and laboratory service, insulin treatment and whirlpool baths prescribed by a physician.
4. Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.

5. Hospital care (including meals and lodging), clinic costs and lab fees.
6. Medical treatment at a center for substance abuse.
7. Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
8. Ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spend for gas and oil to go to and from the place you receive the care; or you can claim 14 cents a mile. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

1. The basic cost of Medicare insurance (Medicare A).
2. Life insurance or income protection policies.
3. Accident or health insurance for you or members of your family.
4. The hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax.
5. Nursing care for a healthy baby.
6. Illegal operations or drugs.
7. Travel your doctor told you to take for rest or change.
8. Cosmetic surgery.
9. Long-term care expenses.

Special Information Regarding Over-the-Counter Medicines

Over-the-Counter Medicines Eligible for Reimbursement

Over-the-counter medicines that have been purchased in reasonable quantities may be reimbursed even if you do not have a medical doctor's note. These include but are not limited to:

Allergy medicine	Menstrual cycle products for pain and cramp relief
Antacids	Motion sickness pills
Bactine	Nasal sinus sprays
Band-aids/Bandages	Nasal strips
Anti-diarrhea medicine	Nicotine gum or patches for stop-smoking purposes
Bug bite medication	Pain reliever
Calamine lotion	Pedialyte for ill child's dehydration
Carpal tunnel wrist supports	Pregnancy test kits
Cold medicines	Products for muscle pain or joint pain, i.e., BenGay, Tiger Balm, etc.
Cold/Hot packs for injuries	Reading glasses
Condoms	Rubbing alcohol
Contact lens cleaning solution	Sinus medications
Cough drops	Sleeping aids used to treat occasional insomnia
Diaper rash ointments	Special ointment or cream for sunburn
First-Aid cream	Spermicidal foam
First Aid kits	Thermometers (ear or mouth)
Hemorrhoid medication	Throat lozenges
Incontinence supplies	Visine and other such eye products
Laxatives	Wart remover treatments
Liquid adhesive for small cuts	

Over-the-Counter Medicines Covered in Special Circumstances

Some over-the-counter medicines may be reimbursed if they are accompanied by a note from a medical doctor indicating they are being purchased to treat a specified illness or condition. These include but are not limited to:

Acne treatment – only to treat a specific medical condition such as acne vulgaris	Pills for persons who are lactose intolerant
Dietary supplements or herbal medicines to treat a specific medical condition in narrow circumstances	Prenatal vitamins
Fiber supplements under narrow circumstances	St John's Wort for depression
Glucosamine/Chondroitin for arthritis or other medical condition	Sunscreen
OTC hormone therapy and treatment for menopause to treat symptoms such as hot flashes, night sweats, etc.	Weight-loss drugs to treat a specific disease (including obesity)

Over-the-Counter Medicines not Covered

Certain over-the-counter medicines are not eligible for reimbursement. These include but are not limited to:

Face cream, moisturizers	One-a-Day® vitamins
Lip moisturizers	Suntan lotion
Medicated shampoos and soaps	

Notes



Pension Boards

United Church of Christ

475 Riverside Drive, Room 1020

New York, NY 10115

www.pbucc.org

800.642.6543

212.729.2701 Fax

rev. FSA-1/07