Lee County Board Of County Commissioners
Agenda Item Summary **Blue Sheet No. 20051018**

1. ACTION REQUESTED/PURPOSE: Approve revision to the Medical and Dependent Care Reimbursement Accounts and Pre-tax Premiums for the Lee County Health, Dental and Vision Plans. Add Opt-Out Plan (previously approved by Board) to document.

2. **WHAT ACTION ACCOMPLISHES:** Updates benefits documents to reflect current regulations and practices of the IRS. This extends the time allowed to claim reimbursement from the Health Care Reimbursement Plan and the Dependent Care Assistance Program for two and a half months (fifteenth day of the third month following the end of the Plan Year). These are "use it or lose it" plans with tax consequences. New regulations give employees additional time to use the money in their accounts.

3. MANAGEMENT RECOMMENDATION: Approve.

4. Departmental Category: 6 CGD		**5. Meeting Date:** 08-09-2005
6. Agenda: x **Consent** ___ **Administrative** ___ **Appeals** ___ **Public** ___ **Walk-On**	**7. Requirement/Purpose:** *(specify)* ___ **Statute** ___ **Ordinance** ___ **Admin. Code** x **Other** **Summary Plan Documents**	**8. Request Initiated:** **Commissioner** **Department** Human Resources **Division** **By: Dinah Lewis**

9. Background:
Health Care Reimbursement Accounts and Dependent Care Assistance Accounts are a means to put aside money on a tax-free basis to pay for anticipated health care or dependent care expenses throughout the year. Employees must anticipate their expenses for the following year at open enrollment each year. If they do not use this money by the end of the Plan Year, it is forfeited. This is the "use it or lose it rule." Beginning with money set aside during 2005, IRS rules allow plans to adopt an additional two and a half month "grace period" in which to spend money in Health Care or Dependent Care Reimbursement Accounts.

10. Review for Scheduling:

Department Director	Purchasing or Contracts	Human Resources	Other	County Attorney	Budget Services				County Manager/P.W. Director
					Analyst	Risk	Grants	Mgr.	
					RK 7/18	7/18/05		7/19/05	

11. Commission Action:
_____ **Approved**
_____ **Deferred**
_____ **Denied**
_____ **Other**

RECEIVED BY COUNTY ADMIN
7-18-05
11:45
COUNTY ADMIN FORWARDED TO:
7/21/05

RECVD. by CO. ATTY.
CO. ATTY. FORWARDED TO:
Admin 7/18

LEE COUNTY HEALTH DENTAL AND VISION BENEFIT PLANS

MEDICAL REIMBURSEMENT ACCOUNT
DEPENDENT CARE REIMBURSEMENT ACCOUNT
PRE-TAX PREMIUMS
OPT OUT PLAN
Revision Effective August 9, 2005

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LEE COUNTY HEALTH ,DENTAL, AND VISION BENEFIT PLANS

INTRODUCTION

The Employer has established this Plan effective January 1, 1990 and amended it ~~January 1, 2005~~ August 9, 2005. Its purpose is to reward Employees by providing benefits for those who shall qualify hereunder, and their dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 1990. The Plan shall be known as Lee County Health and Dental Benefit Plans Medical Reimbursement Account (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be includible or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 "Affiliated Employer" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "Benefit" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "Cafeteria Plan Benefit Dollars" means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 "Compensation" means base compensation plus regularly scheduled over-time.

1.7 "Dependent" means any individual who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)).

1.8 "Effective Date" means January 1, 1990.

1.9 "Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 "Eligible Employee" means any Employee who has satisfied the provisions of Section 2.1.

1.11 "Employee" means any person who is employed by the Employer, but excludes any person who is employed as an independent contractor.

1.12 "Employer" means Lee County Board of County Commissioners and any other government entity which is a member of this plan and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

1.13 "Grace Period" means the two and a half months (fifteenth day of the third month) immediately following the end of each Plan Year during which unused benefits or contributions remaining at the end of the Plan Year may be used by Plan Participants for qualified expenses incurred during the Grace Period.

1.14 "Insurance Contract" means any contract issued by an Insurer underwriting a Benefit.

1.15 "Insurer" means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits for, the Employer.

1.16 "Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.17 "Opt Out Plan" means any plan whereby eligible employees may choose not to enroll in the medical portion of the health plan in return for compensation to be given each month in their paychecks. This plan must be elected for an entire year. This compensation is subject to all applicable taxes.

1.18 "Participant" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 "Plan" means this instrument, including all amendments.

1.20 "Plan Year" means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on the Participant's date of entry and ending on the last day of such Plan Year.

1.21 "Premium Expenses" or "Premiums" mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.22 "Premium Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.23 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 "Spouse" means the legally married husband or wife of a Participant.

ARTICLE II
PARTICIPATION

The Plan is administered by the Lee County Board of County Commissioners, but is comprised of several separate entities. Each entity may chose the plan(s) in which it may wish to participate, but all eligible members of that entity must be given the option of electing to become a Participant of the plans selected by that group.

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee ~~shall~~ May elect to become a Participant effective as of the date on which he satisfies the requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits form which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period The minimum redirection shall be ten ($10.00) per pay period for 24 pay periods per plan year beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) His termination of employment, subject to the provisions of Section 2.5;

(b) His death, subject to the provisions of Section 2.6; or

(c) The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

(a) With regard to Insurance Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease at the end of the month in which he terminates, subject to the Participant's right to continue coverage under ~~any Insurance Contract for which premiums have already been paid~~ COBRA.

(b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for the remainder of the Plan Year in which such termination occurs, based on the level of his Dependent Care Assistance Account as of his date of termination.

(c) With regard to the Health Care Reimbursement Plan, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his date of termination.

(d) With regard to the Opt-Out Plan, participation shall cease when the Participant terminates

(e) In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(f) This Section shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Each Participant may elect to have his salary reduced pursuant to a Salary Redirection Agreement. Such Salary Redirection Agreement must be executed during the applicable Election Period. The amount of the Salary Redirection a Participant may elect for each Plan Year shall be up to $5,000. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are

deemed to be part of this Plan and incorporated by reference hereunder. The minimum redirection shall be ten dollars ($10.00) each pay period for 24 pay periods per year ($240)

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for twenty-four pay periods per year, or consistent with participating entities' payroll procedures. If the redirection of salary is not in twenty-four equal installments, the minimum deduction shall equal $240 per year in equal installments. This applies both to the health care reimbursement account and the Dependent Care Assistance Program. New employees who enroll mid-year shall have salary redirections equal to ten dollars per pay period or twenty dollars per month. Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.5.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect to have the amount of his Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

(1) Health Care Reimbursement Plan

(2) Dependent Care Assistance Program

(3) Opt Out Plan

(4) Benefit Payment Plan

(i) Health Benefit

(ii) Dental Benefit

(iii) Vision Benefit

4.2 HEALTH CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Health Care Reimbursement Plan option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

Each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) Each Participant may elect to be covered under a health and hospitalization Contract for the Participant, his or her spouse, and his or her Dependents.

(b) The Employer may select suitable health and hospitalization Contracts for use in providing this health benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such health and hospitalization Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's dental Contract. In addition, the Participant may elect either individual or family coverage under such Contract.

(b) The Employer may select suitable dental Contracts for use in providing this dental benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such dental Contract shall be determined therefrom, and such dental Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's vision Contract. In addition, the Participant may elect either individual or family coverage.

(b) The Employer may select suitable vision Contracts for use in providing this vision benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such vision Contract shall be determined therefrom, and such vision Contract shall be incorporated herein by reference.

4.7 OPT-OUT PLAN

Lee County may offer an incentive for employees to opt not to join the medical plan. This plan is applicable only to medical insurance.

(a) In lieu of electing medical insurance, an Eligible Employee may elect to waive medical coverage for an incentive payment (Opt-Out Plan). The person electing the Opt-Out Plan may not be a dependent on the medical plan in any capacity, including as a dependent of his spouse. The incentive amounts will be taxable to the employee. An employee who has elected to opt out of the health insurance cannot cover his dependents for health insurance.

(b) The Eligible Employee must show that he has health insurance from another source. It is the responsibility of the Employee to ensure that he has adequate coverage.

(c) He must elect this benefit in writing at the Election Period, to be effective on January 1 of the following Plan Year.

(d) Once enrolled, this benefit will automatically roll over each year unless the employee has rejoined the medical plan during the Election Period. Rejoining the medical plan will automatically stop the Opt Out Plan.

(e) Employees who waive coverage in the medical plan (Opt Out) may rejoin the medical plan only at the yearly Election Period or with a documented qualifying event reported within 60 days. The employee who rejoins the Plan with a Qualifying Event may not Opt Out again for the remainder of the Plan Year until the next Election Period.

(f) The medical, dental, and vision plans are elected separately. Only the medical plan is eligible for the Opt-Out incentive.

4.8 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the

Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program Benefits, and once all these Benefits are expended, proportionately among insured self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select and purchase with his Cafeteria Plan Benefit Dollars. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan.

5.3 FAILURE TO ELECT

Any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be treated in the following manner:

(a) With regard to Benefits available under the Plan for which no Premium Expenses apply, such Participant shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

(b) With regard to Benefits available under the Plan for which Premium Expenses apply, such Participant shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE OF ELECTIONS

(a) Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control. All changes must be reported to the Plan Administrator within 60 days of the event.

In general, a change in election is consistent with an acceptable change if the change in status if it is for the individual(s) directly involved in the event.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations: The Plan Administrator must be notified of all changes within 60 days of the event.

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a spouse or annulment;

(2) Number of Dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, spouse, or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, spouse or dependent which changes the coverage.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) Notwithstanding subsection (a), in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires health coverage for a Participant's child (including a foster child who is a dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(c) Notwithstanding subsection (a), a Participant may change elections to cancel health coverage for the Participant or the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's

spouse or dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(d) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection.

ARTICLE VI
HEALTH CARE REIMBURSEMENT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) "Health Care Reimbursement Fund" means the fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.

(b) "Health Care Reimbursement Plan" means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents.

(c) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(d) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. This includes allowed over-the-counter medications. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his spouse or Dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 FORFEITURES

The amount in the Health Care Reimbursement Fund as of the end of any Plan Year plus the two and a half months grace period (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, no more than $5,000 may be allocated to the Health Care Reimbursement Fund by a Participant in or on account of any Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Reimbursement Plan. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Reimbursement Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH CARE REIMBURSEMENT PLAN CLAIMS

(a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year plus the grace period. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for them.

(b) There will be a Grace Period at the end of the plan year until the fifteenth day of the third calendar month following the end of the Plan Year to incur qualified expenses. Amounts not used by the end of the Grace Period will be forfeited.

(c) The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments under any health care plan covering the Participant and/or his Spouse or Dependents.

(d) Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim ~~within the 90 day period~~ by April fifteenth of the year immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(e) Reimbursement payments under this Plan shall be made directly to the Participant.

(f) Claims Review Procedure. Within 180 days following receipt by the Participant of notice of the claim denial, or within 180 days following the close of the 60-day period referred to in Section 9.3 (c) if the Plan Administrator or its representative fails to notify the Participant of the decision during such time period, the Participant may appeal denial of the claim. The Participant shall be given an opportunity to review pertinent documents and to submit written

comments, documents, records and other information relating to the claim for benefits. Following such request for review, the Plan Administrator or its representative shall fully and fairly review the decision denying the claim.

(g) Over-the-Counter medications as allowed under Section 213 of the IRS code must be submitted to the Plan Administrator with a receipt showing the name of the medication and the date purchased. A form must be submitted stating that this medication is for the employee or dependent. Cosmetics and toiletries are specifically excluded. In the case of items which may have a dual use, a doctor's note will be required.

ARTICLE VII
DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) "Dependent Care Assistance Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.

(b) "Dependent Care Assistance Program" means the program of benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(d) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having

been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(e);

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.

(e) "Qualifying Dependent" means, for Dependent Care Assistance Program purposes,

(1) A Dependent of a Participant who is under the age of 13, with respect to whom the Participant is entitled to an exemption under Code Section 151(c);

(2) A Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself; or

(3) A child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate.

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Assistance Program benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This may be in electronic format.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year plus the Grace Period (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

There will be a Grace Period at the end of the plan year until the fifteenth day of the third calendar month following the end of the Plan Year to incur qualified expenses. Amounts not used by the end of the Grade Period will be forfeited.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) If a Participant fails to submit a claim ~~within the 90 day period~~ by April fifteenth of the year immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Any claim for Benefits underwritten by Contracts shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure. Any other claim for Benefits shall be made to the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing,

within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator does not notify the Participant of the denial of the claim within the 90 day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(b) Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(c) A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(d) Any balance remaining in the Participants' Health Care Reimbursement Fund or Dependent Care Assistance Account as of the end of each Plan Year (or within the Grace Period) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

(e) Notwithstanding the foregoing, in the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims and rules below apply:

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's review procedures and the time limits applicable to such procedures. This will include a statement of the 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 the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time 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 are 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.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by the Employer.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits; and

(g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Florida.

11.11 SEVERABILITY

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

11.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.13 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

11.14 FAMILY AND MEDICAL LEAVE ACT

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

Employees on unpaid FMLA may be treated the same as having experienced a change in family status, and may change their benefit elections, or may "catch up" their salary redirection when they return.

11.15 DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

(a) Definitions. Whenever used in this Section, the following terms shall have the respective meanings set for below.

(1) "Plan Administration Functions" shall mean administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(2) "Health Information" shall mean information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR 160.103), employer, life insurer, school or university or health care clearinghouse (as defined in 45 CFR 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provisions of health care to an individual.

(3) "Individually Identifiable Health Information" shall mean Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(4) "Summary Health Information" shall mean information, including Individually Identifiable Health Information, that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (A) names; (B) geographic information more specific than state; (C) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older; (D) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN or serial numbers; (E) facial photographs or biometric identifiers (e.g., finger prints) and (F) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(5) "Protected Health Information 'PHI')" shall mean Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(b) Summary Health Information. The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of modifying, amending, or terminating the Plan.

(c) Permitted Disclosures. The Plan will disclose PHI to the Employer only in accordance with 45 CFR 164.594(f) and the provisions of this Section. PHI disclosed to the Employer in accordance with this Section may only be used for the following permitted and required uses and disclosures;

- claims monitoring
- claims assistance
- claims auditing

(d) The Plan hereby incorporated the following provisions (1) through (10) to enable it to disclose PHI to the Employer and acknowledges receipt or written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

(1) not to use or further disclose PHI other than as permitted in this Section or as required by law;

(2) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

(3) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

(4) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this paragraph;

(5) to make PHI available to individuals in accordance with 45 CFR 164.524;

(6) to make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR 164.526;

(7) to make the information available as required to provide individuals with an accounting of disclosures in accordance with 45 CFR 164.528;

(8) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and

(9) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction or the information infeasible,

(10) to ensure that adequate separation between the Plan and the Employer, as required by 45 CFR 164.504(f), is established and maintained.

(e) Disclosure to Employees. The Plan will disclose PHI only to the following employees or classes of employees:

- Director of Human Resources;
- Manager of Human Resources; and
- Their designees

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(f) Noncompliance. Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section 11.15(e) shall be addressed in the following manner: The degree of noncompliance will be reviewed and remedial action will be taken which may include removing an offending employee from the select group with Access to PHI.

(g) A health insurance issuer or HMO providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Section 11.15 and only if a notice is maintained and provided as required by 45 CFR 164.520.

11.16 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

Employees who are called to active duty shall be treated the same as having experienced a change in family status, and may change their benefit elections.