Agenda Item No.	Board Meeting Date	Open/Closed Session	Information/Action Item	Issue Date
3	01/09/12	Open	Action	12/08/11

Subject: Approving the New Cafeteria Plan, Effective January 1, 2012, for Sacramento Regional Transit District

ISSUE

Whether or not to Approve a New Cafeteria Plan Effective January 1, 2012 for Sacramento Regional Transit District.

RECOMMENDED ACTION

Adopt Resolution No. 12-01-____, Approving the New Sacramento Regional Transit District Cafeteria Plan, Effective January 1, 2012.

FISCAL IMPACT

There is no fiscal impact associated with this action.

DISCUSSION

Effective January 1, 2012, Sacramento Regional Transit District contracted with Employee Benefit Specialists, Inc. (EBS) to provide a variety of benefit services, including Cafeteria Plan administration. To facilitate that administration, EBS has requested the District adopt a new Cafeteria Plan document, ensuring that the Plan is up-to-date and includes all federally mandated changes, including the Mental Health Parity and Additional Equity Act, Genetic Information Nondiscrimination Act, and the Patient Protection and Affordability Care Act of 2010.
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Staff recommends approval of the new Cafeteria Plan for Sacramento Regional Transit District.

Approved: Presented:

Final 1/3/12

General Manager/CEO Director, Human Resources

RESOLUTION NO. 12-01-_____

Adopted by the Board of Directors of the Sacramento Regional Transit District on this date:

January 9, 2012

APPROVING THE NEW SACRAMENTO REGIONAL TRANSIT DISTRICT CAFETERIA PLAN, EFFECTIVE JANUARY 1, 2012

BE IT HEREBY RESOLVED BY THE BOARD OF DIRECTORS OF THE SACRAMENTO REGIONAL TRANSIT DISTRICT AS FOLLOWS:

THAT, the New Sacramento Regional Transit District Cafeteria Plan, (Exhibit A), including a Dependent Care Flexible Spending Acount and Health Flexible Spending Account is hereby approved.

THAT, the General Manager/CEO is hereby authorized and directed to execute the Sacramento Regional Transit District Cafeteria Plan and deliver to the Administrator of the plan the approved document.

THAT, the General Manager/CEO or his designee must notify employees of the approved of the Cafeteria Plan by delivering to each employee a copy of the summary description of the Plan.

_____
DON NOTTOLI, Chair

A T T E S T:

MICHAEL R. WILEY, Secretary

By: _____
Cindy Brooks, Assistant Secretary

EXHIBIT A

SACRAMENTO REGIONAL TRANSIT DISTRICT
CAFETERIA PLAN
PLAN DOCUMENT #125

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SACRAMENTO REGIONAL TRANSIT DISTRICT CAFETERIA PLAN
PLAN DOCUMENT
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ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("PLAN DOCUMENT") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b) and reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, will be determined under the provisions of the Plan in effect prior to that date.

ARTICLE 2
DEFINITIONS

"Account" means the balance of a hypothetical account established for each Participant as of the applicable date. "Account" or "Accounts", include to the extent provided in the Adoption Agreement, a Premium Conversion Account, a Health Care Reimbursement Account, a Dependent Care Assistance Account, an Adoption Assistance Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Adoption Agreement" means the document executed in conjunction with this Plan Document that contains the optional features selected by the Plan Sponsor.

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

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" means the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" means Section 414(s) Compensation (defined below).

"Dependent Care Assistance Account" means the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Section 4.03.

"Effective Date" has the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the Company, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual will not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business will not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means any individual who is employed by the Employer. The term "Employee" does not include: (i) a self-employed individual (including a partner) as defined in

Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" does not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993 as amended from time to time.

"Health Care Reimbursement Account" means the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Section 4.02.

"Contract" means an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. Contract does not include any product which is advertised, marketed, or offered as long-term care insurance. As of January 1, 2014, "Contract" may not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employee's Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Premium Conversion Account" means the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Section 4.01.

"Section 414(s) Compensation" means compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine

the compensation of every eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an eligible Employee, provided that this limit is applied uniformly to all eligible.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the Company.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date will be a Participant eligible to make benefit elections pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date will become a Participant eligible to make benefit elections pursuant to Article 4 on the date specified in the Adoption Agreement if he or she is an Eligible Employee on such date. Notwithstanding the foregoing, a Participant will be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 TRANSFERS

If an Employee changes job classification or transfers to a new position such that the Employee is no longer qualified as an Eligible Employee, such Employee will cease to be a Participant for purposes of Article 4 (or will not become eligible to become a Participant) as of the effective date of such change of job classification or transfer; unless otherwise provided in the Adoption Agreement. If such Employee again qualifies as an Eligible Employee, he or she will be eligible to participate as of the first day of the subsequent Plan Year; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 4.07(a). If an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he or she will be eligible to participate as specified in Section 3.01.

Section 3.03 TERMINATION AND REHIRES

(a) Participants. If a Participant has a Termination of Employment, such Employee will cease to be a Participant for purposes of Article 4 as of his or her Termination of Employment. The Plan Administrator may continue participation for purposes of Article 4.01 until the end of the calendar month coincident with or next following the Termination of Employment or other timeframe according to established Plan Administrator procedures. Unless otherwise provided in the Adoption Agreement, if an individual has satisfied the applicable eligibility requirements set forth in Article 3 as of his or Termination date, and is subsequently reemployed by the Company as an Eligible Employee, he or she will resume or become a Participant as of the later of the first day of the subsequent Plan Year or the first date he or she becomes eligible to participate following reemployment. Notwithstanding the foregoing and if so provided in the Adoption Agreement, the Plan Administrator will automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination.

(b) Non-Participants. An Eligible Employee who has not satisfied the applicable eligibility requirements set forth in Article 3 on his Termination date, and who is subsequently

reemployed by the Company as an Eligible Employee, will be eligible to participate on the first entry date following the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator will prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections made pursuant to Article 4.

ARTICLE 4
ACCOUNTS

Section 4.01 PREMIUM CONVERSION ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account may not exceed the employee-paid portion of premiums payable under the Contracts specified in the Adoption Agreement. If a Contract is offered in conjunction with a Company-sponsored benefit plan, a Participant will be eligible to make contributions to the Premium Conversion Account with respect to that Contract only if he or she is also eligible to participate in the applicable Company-sponsored plan. The Account established under this Section 4.01 is intended to qualify under Code Sections 79 and 106(a) to the extent so indicated in the Adoption Agreement and must be interpreted in a manner consistent with such Code sections. Elections for Code section 79 coverage will be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

(b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for amounts applied to employee-paid portion of applicable premiums. However, the Plan Administrator will not direct the Company to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

(c) Conflicts. In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) will control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits Participants are entitled to and the circumstances under which coverage terminates.

Section 4.02 HEALTH CARE REIMBURSEMENT ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Health Care Reimbursement Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Health Care Reimbursement Account described in Subsection (b). The amount of such salary reduction contributions to the Health Care Reimbursement Account must not exceed the maximum annual limit described in the Adoption Agreement. The Account established under this Section 4.02 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and will be interpreted in a manner consistent with such Code sections.

(b) Health Care Reimbursement Account. Each Participant's Health Care Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Reimbursement Account, if the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.

(c) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Health Care Reimbursement Account for expenses that are: (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

(1) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, expenses for a child (as defined in section 152(f)(1)) of the Participant may be covered until his or her 26th birthday although the Plan Administrator may extend coverage until the end of the calendar year in which the child turns age 26.

(2) Effective January 1, 2011, reimbursement for expenses incurred for a medicine or a drug will be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(d) Qualified Reservist Distributions.

(1) If the Plan allows Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his Health Care Reimbursement Account specified in the Adoption Agreement if such amount was in existence on or after June 18, 2008. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Participant ordered or called to active duty before June 18, 2008 is eligible for a Qualified Reservist Distribution if the Participant's period of active duty continues after June 18, 2008 and meets the duration requirements of IRS Notice 2008-82. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(2) The Plan will permit a Participant to submit Health Care Reimbursement Account claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant will not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Company will pay

the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(3) This Subsection will be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 4.03 DEPENDENT CARE ASSISTANCE ACCOUNTS

(a) In General. To the extent the Adoption Agreement authorizes Dependent Care Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Dependent Care Assistance Account described in Subsection (b). The Account established under this Section 4.03 is intended to qualify as a dependent care assistance program under Code Section 129 and will be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Dependent Care Assistance Account. Each Participant's Dependent Care Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the Company to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Dependent Care Assistance Account to the extent that such reimbursement: (i) is incurred in the Plan Year (except as provided in Section 4.05(c), (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses, of such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Dependent Care Expenses. Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual but do not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a

state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is $5,000 ($2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) applies in determining earned income.

(d) If the Plan allows Employees that cease to be Participants in the plan to spend down unused Dependent Care Assistance Account expenses, Employees that cease to Participate in the Plan (due to Termination or any other reason) may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or grace period if provided in the Plan) to the extent the claims do not exceed the balance of the Dependent Care Assistance Account.

Section 4.04 ADOPTION ASSISTANCE ACCOUNTS

Intentionally Omitted.

Section 4.05 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year (or after the grace period if Subsection (c) applies) will be forfeited and remain the property of the Company. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination will be forfeited and remain the property of the Company. However, no forfeiture will occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Transfers. Amounts may not be transferred between Accounts.

(c) Grace Period. If the Adoption Agreement provides for a 2-1/2 month grace period, effective for grace periods beginning on or after the date specified in the Adoption Agreement and notwithstanding anything to the contrary in the Plan, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period. The grace period will commence on the first day of the subsequent Plan Year and end on the fifteenth day of the third calendar month of the subsequent Plan Year. Unless otherwise provided in the Adoption Agreement, the grace period applies to all Accounts in which the Participant is eligible to Participate. Payment or reimbursement of unused benefits is subject to the following terms and conditions:

(1) Same Account. Unused contributions remaining at the end of a Plan Year relating to a particular Account may only be used to reimburse expenses incurred with respect to that Account.

(2) No Cash Out. Unused contributions remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(3) No Carryforward. Any unused contributions remaining at the end of a Plan Year that exceed the expenses for a particular Account that are incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and will be forfeited.

(4) Construction. This Section 4.05(c) is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

Section 4.06 ELECTIONS

(a) New Participants. The Plan Administrator will provide, where possible, an election form to a Participant before such Participant meets the eligibility requirements of Article 3. To participate in the Plan in the initial Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date as specified by the Plan Administrator. However, any election will not be effective until a pay period following the later of: (1) such Participant's effective date of participation pursuant to Article 3; or (2) the date of receipt of the election form by the Plan Administrator and will be limited to the expenses incurred after the effective date of the election.

(b) Continuing Participants. Prior to the commencement of each Plan Year, the Plan Administrator will provide an election form to each Participant and to each other individual who is expected to become a Participant at the beginning of such Plan Year. To participate in the Plan in the applicable Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date specified in the Adoption Agreement, which date will be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.

(c) Failure to Return Election Form. The failure of a Participant described in Subsection (a) to return a completed election form to the Plan Administrator on or before the specified due date will constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of a Participant described in Subsection (b) to return a completed election form to the Plan Administrator on or before the specified due date will constitute an election not to participate for the applicable Plan Year unless a default election is otherwise specified in the Adoption Agreement or under Subsection (d).

(d) Premium Conversion Special Election Rules. If elected in the Adoption Agreement, a Participant will be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefits described in Section 4.01 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. If elected in the Adoption Agreement, a Participant's election for benefits described in Section 4.01 will be automatically adjusted for any change in the cost of premiums pursuant to the terms of Treas. Reg. 1.125-4.

(e) Form of Elections. All elections must be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Plan Administrator determines that the Plan is subject to FMLA, the Plan Administrator must permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law unless otherwise specified in the Adoption Agreement. To the extent provided in the Adoption Agreement, the Plan Administrator must also permit a Participant taking unpaid Non-FMLA leave to continue the benefits specified in the Adoption Agreement. Participants continuing participation pursuant to the foregoing must pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage must be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator will permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and will provide such reinstatement rights as required by such law. The Plan Administrator will also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(g) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan is subject to COBRA, a Participant will be entitled to continuation coverage as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

(h) Procedures. A Participant must make the elections described in this Section in such form and manner as may be prescribed by the Plan Administrator and at such time in advance as the Plan Administrator may require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

Section 4.07 REVOCATION OF ELECTIONS

(a) By Participant. Any election made under this Article 4 will be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions of the Federal Family and Medical Leave Act or other applicable law and is permitted under Treas. Reg. 1.125-4 and the provisions of the Adoption Agreement. If the Adoption Agreement provides that elections may be modified at any time permitted under Treas. Reg. section 1.125-4, elections may be modified upon the occurrence of any of the following events:

(1) HIPAA Special Enrollment Rights. Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).

(2) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(E) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.

(A) Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(B) Number of Dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption.

(C) Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4 and Section 3.03, change in employment status resulting in gaining or losing eligibility under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, spouse, or dependent.

(3) Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:

(A) changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or

(B) cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.

(4) Entitlement to Medicare or Medicaid. A Participant may modify an election for benefits attributable to a Company-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan will be granted in the case of loss of coverage under Medicare or Medicaid.

(5) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 4.02, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

(6) FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(b) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection must be carried out in a uniform and non-discriminatory manner.

(c) Automatic Termination of Election. Any election made under this Section will automatically terminate on the date specified in Sections 3.02 or 3.03.

(d) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 4.07 and whether the Participant's requested election change is consistent with such event.

Section 4.08 HEALTH SAVINGS ACCOUNTS SPECIAL RULES

Intentionally Omitted.

Section 4.09 EMPLOYER CONTRIBUTIONS

The Company may contribute to the Plan to the extent provided in the Adoption Agreement. Such contributions will be credited to the applicable Account at such time as determined by the Company.

ARTICLE 5
LIMITATIONS ON CONTRIBUTIONS

Section 5.01 NONDISCRIMINATION

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) will be treated as met during such year.

(a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.

(b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) Health Care Reimbursement Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.02.

(d) Dependent Care Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.03.

Section 5.02 LIMITATIONS ON CONTRIBUTIONS

(a) Cafeteria Plan. Key employees (within the meaning of Code section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all employees under the Plan.

(b) Dependent Care Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 25% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.03. The average benefits provided under Section 4.03 to Participants who are not highly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees of the Company.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Contracts. All claims for benefits that are provided under Contracts must be made by the Participant to the Company issuing such Contract.

(b) Timing of Claims. Reimbursements and/or payments will be made only for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment will be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the Company will: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Plan Administrator must establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided that the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

(e) Coordination with HRA. A Participant who is also eligible to participate in a Code section 105 health reimbursement arrangement ("HRA") sponsored by the Company is not entitled to payment/reimbursement under the Health Care Reimbursement Account for expenses that are reimbursable under both the Health Care Reimbursement Account and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant is entitled to payment/reimbursement under the Health Care Reimbursement Account if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the Health Care Reimbursement Account have been paid.

(f) Death. If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is

specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her dependents or a representative of the Participant's estate. Such payment will fully discharge the Plan Administrator and the Company from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices must be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator will notify the Claimant and the Claimant must repay such excess amount (or, at the option of the Plan Administrator, the Claimant must pay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant must indemnify and reimburse the Company for any liability the Company may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the Company may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.02 and/or Section 4.03 provided that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits under Sections 4.02 and 4.03 without the use of the card.

(j) HSA Coordination. Except as otherwise provided in the Adoption Agreement, benefits under this Plan are not coordinated with coverage in a high deductible health plan to facilitate participation in Health Savings Accounts.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE FOR HEALTH CARE REIMBURSEMENT ACCOUNT

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the Participant's inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) This Section 6.02(b) applies to any claim for benefits under the Health Care Reimbursement Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, if the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator must provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he or she wishes to appeal the denial, including a statement that the Claimant may bring a civil action under ERISA, and (E): (I) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (II) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he or she must file an appeal with the Plan Administrator on or before the 180th day after he or she receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant will lose the right to appeal if the appeal is not timely made.

The Plan Administrator will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator must:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator must notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

(4) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator must provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) 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 Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section

502(a) of ERISA, if applicable. The determination rendered by the Plan Administrator is binding upon all parties.

(5) Exhaustion of Remedies. Before a suit can be filed in federal court, Claimants must exhaust internal remedies.

(c) Additional Internal and External Claims Procedure for Health Care Reimbursement Account.

(1) Applicability. This Section applies to any claim for benefits under the Health Care Reimbursement Account if (A) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (B) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Effective Date. This Section is effective the later of: (A) the first plan year beginning after September 23, 2010; or (B) the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(3) Internal Claims Process. The requirements under Section 6.02(b) apply as the internal appeals process except as modified below. This section is intended to satisfy the requirements of DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(C) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(D) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL

Reg. 2590.715-2719(b)(2)(ii)(F)(2), the Claimant may initiate an external review under Section 6.02(c)(2), below, or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(2) External Claims Process.

(A) State External Claims Process. If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State claims review process.

(B) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (c)(2)(A) above is not applicable.

(d) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. section 54.9801-2 or the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, claims procedures will be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.03 CLAIMS PROCEDURES FOR NON-HEALTH BENEFITS

(a) This Section 6.03 applies to any claim for benefits under Accounts other than the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator must notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, if the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator must provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(d) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he or she must file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal must identify both the grounds and specific Plan provisions upon

which the appeal is based. The Claimant must be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator must consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made. The Plan Administrator will ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator must provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) 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 Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA, if applicable. The determination rendered by the Plan Administrator is binding upon all parties.

(f) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that the Plan is not subject to ERISA, claims procedures will be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.04 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment will fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.05 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator will be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor will be the Plan Administrator.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator will be the Plan "administrator" as such term is defined in section 3(16) of ERISA (if the Adoption Agreement provides that the Plan is subject to ERISA), and as such will have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator will be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator is entitled to rely upon information furnished to it. The Plan Administrator's decisions will be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder will be paid or reimbursed by the Company.

(f) Allocation of Fiduciary Duties. A Plan fiduciary will have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary will not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company must indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Adoption Agreement provides the Plan is subject to ERISA.

Section 7.03 HIPAA PRIVACY RULES

(a) Application. This Section 7.03 applies only in the event that this Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy rules.

(b) Privacy Policy. The Plan must adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.

(c) Business Associate Agreement. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.

(d) Notice of Privacy Practices. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.

(e) Disclosure to the Company.

(1) In General. This Subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Plan.

(2) Permitted Disclosure. The Plan may disclose the PHI to the Company that is necessary for the Company to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Company may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Subsection.

(3) Limitations. The Company agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

(A) Use and Further Disclosure. The Company must not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Plan, the Company must make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(B) Agents and Subcontractors. The Company must require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Company with respect to such information.

(C) Employment-Related Actions. Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company must not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.

(D) Reporting of Improper Use or Disclosure. The Company must promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(E) Adequate Protection. The Company must provide adequate protection of PHI and separation between the Plan and the Company by: (i) ensuring that only those employees who work in the human resources department of the Company on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the Company on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's

privacy rules; and (iv) using the Company's established disciplinary procedures to resolve issues of noncompliance by the employees identified in clause (i) above.

(F) Return or Destruction of PHI. If feasible, the Company must return or destroy all PHI received from the Plan that the Company maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Company must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(G) Participant Rights. The Company must provide Participants with the following rights: (i) the right to access to their PHI in accordance with 45 C.F.R. §164.524; (ii) the right to amend their PHI upon request (or the Company will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. §164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

(H) Cooperation with HHS. The Company must make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

(4) Certification. By executing the accompanying Adoption Agreement, the Company hereby certifies that the Plan documents have been amended in accordance with 45 C.F.R. §164.504(f), and that the Company must protect the PHI as described in Subsection 3 herein.

(5) Security Standards Requirement. To comply with the Security Standards regulations that were published on February 21, 2003, the Company must:

(A) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(B) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(C) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(D) report to the Plan any security incident of which it becomes aware.

(6) Amendment. Notwithstanding any other provision of the Plan, this Section may be amended in any way and at any time by the Privacy Officer.

(7) Effective Dates. Subsections (1) – (4) and Subsection (6) apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply

to the Plan. Section (5) applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

Section 7.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator must notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator must determine whether the order is a qualified medical child support order and must notify the Participant and alternate recipient of such determination.

If the plan is not subject to ERISA any applicable law related to qualified medical child support orders or National Medical Support Notices will apply and the Plan Administrator must follow any required procedures under such law.

Section 7.05 HIPAA PORTABILITY RULES

If the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan must comply with the requirements of Code section 9801 et. Seq. The Plan Administrator must provide a certificate of creditable coverage only if the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. Each such entity constituting the Company will be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary has the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan will be construed as a contract of employment between the Company and the Participant, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder remains part of the general assets of the Company and all payments of benefits under the Plan will be made solely out of the general assets of the Company.

(b) The Company has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person has any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this

Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

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

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, will not be considered part of the Plan, and will not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter include the feminine and the neuter, the singular includes the plural, and vice-versa.