MCGREGOR INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFITS PLAN
PLAN DOCUMENT

(As Adopted Effective November 1, 1988)

(As Amended and Restated Effective October 1, 2003)

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PREAMBLE

Effective November 1, 1988, McGregor Independent School District established the Flexible Benefits Plan (the "Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

Effective October 1, 2003, McGregor Independent School District has amended and restated the Plan as set forth herein.

The Dependent Care Reimbursement Account ("DCRA") is intended to qualify as a Code Section 129 dependent care assistance plan, and the Health Care Reimbursement Account ("HCRA") is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the DCRA and HCRA Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code.

MCGREGOR INDEPENDENT SCHOOL DISTRICT
Flexible Benefits Plan

ARTICLE I
DEFINITIONS

1.01 "Affiliated Employer" means any entity who, within the context of Code Section 414(b), (c), or (m) of the Code, will be considered with the Employer as a single employer for purposes of Code Section 125.

1.02 "After-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement, after any applicable state and federal taxes have been deducted, for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

1.03 "Anniversary Date" means the first day of any Plan Year.

1.04 "Benefit Credits" means any amount which the Employer may provide to Participants to apply towards the cost of one or more of the Benefit Package Option(s) elected by the Participant. The amount of Benefit Credits allocated to eligible Participants may be adjusted upward or downward in the contributing Employer's sole discretion. The amount of Benefit Credits and the extent of the Participant's discretion to use the Benefit Credits shall be disclosed in Appendix C attached hereto (and/or the enrollment materials). The amount of the Benefit Credits, if any, shall be calculated each Plan Year in a uniform and nondiscriminatory manner based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. The Benefit Credits may be limited as designated in Appendix C (and/or the enrollment materials). Benefit Credits will not be disbursed to a Participant in the form of additional Compensation if the total cost of the Benefit Package Option(s) elected by the Participant is less than the Benefit Credits allocable thereto or if the Employee declines coverage under the Benefit Package Option(s), except as otherwise provided in the Appendix C attached hereto (and/or the enrollment material). Any excess shall be returned to the Employer.

1.05 "Benefit Package Option(s)" means those Qualified Benefits available to a Participant under this Plan attached hereto as Appendix A, as amended and/or replaced from time to time. The Benefit Package Options offered under this Plan are listed in Appendix A, attached hereto and incorporated herein.

1.06 "Board of Directors" means the Board of Directors of the Employer. The Board of Directors, upon adoption of this Plan, appoints the Committee to act on the Employer's behalf in all matters regarding the Plan.

1.07 "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125 which the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis:

(a) *Legal Marital Status:* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(b) *Change In Number of Tax Dependents (as defined in Section 1.10):* A change in the Participant's number of tax Dependents, including the birth of a child, the adoption or placement for adoption of a Dependent, or the death of a Dependent;

(c) *Change in Employment Status:* Any change in employment status of the Participant, the Participant's Spouse or the Participant's Dependents that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan (including the Benefit Package Option(s) of the Employer of the Participant, the Spouse, or Dependents, such as: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or part-time to full-time or vice versa; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit.

(d) *Dependent Eligibility Requirements:* An event that causes a Participant's Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, getting married, or ceasing to be a Student;

(e) *Change in Residence:* A change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependent.

Note: See Section 3.04 for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.08 "Code" means the Internal Revenue Code of 1986, as amended.

1.09 "Compensation" means the cash wages or salary paid to an Employee by the Employer.

1.10 "Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152(a); provided, however, that in the case of a divorced Employee: i) Dependent shall be defined as in Code Section 21(e)(5) (i.e. dependent of the parent with

custody) for purposes of the Dependent Care Reimbursement Plan; and ii) for purposes of accident or health coverage, a child shall be considered a Dependent of both parents.

1.11 "Dependent Care Reimbursement" shall have the meaning assigned to it by Section 5.01(c) of the Plan.

1.12 "Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includable in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any Dependent Care Reimbursement Plan established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.13 "Effective Date" of this Plan means November 1, 1988. The amendment and restatement effective date of this Plan is October 1, 2003.

1.14 "Eligible Employment Related Expenses" means those Qualifying Employment-Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care Reimbursement Account and during the Plan Year, other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Section 151(a) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the year in which the expenses were incurred.

1.15 "Eligible Individual Premium Expenses" means amounts paid by an Employee who is eligible for this Plan pursuant to Section 2.01 for an individual accident and health insurance policy (including a policy that provides health, dental, vision, and disability benefits) for which the Employee is the policyholder to the extent that (i) the accident or health insurance policy is not maintained by an employer, (ii) the amounts paid by the Employee would be excluded from gross income pursuant to Code Section 106 if the amounts were paid by the Employer, (iii) prior to the beginning of the Plan Year, the accident or health insurance policy was determined to be a Benefit Package Option (as defined in Section 1.05 herein) by the Plan Administrator pursuant to procedures established by the Plan Administrator and (iv) such expenses will not be used in calculating any individual income tax deduction allowed for medical expenses under Section 213 of the Code.

1.16 "Eligible Medical Expenses" means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the HCRA and during the Plan Year to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): (i) expenses for qualified long term care services (as defined in Code § 7702B) and (ii) expenses for health insurance premiums. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.17 "Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to, those individuals defined in Code § 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

1.18 "Employer" means McGregor Independent School District and any Affiliated Employer authorized by McGregor Independent School District to adopt the Plan and who adopts the Plan, provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only McGregor Independent School District. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in Appendix B, attached hereto and incorporated herein.

1.19 "Health Care Reimbursement" shall have the meaning assigned to it by Section 5.01(b) of the Plan.

1.20 "Highly Compensated Individual" means an individual defined under Code Section 105(h), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.21 "Individual Premium Reimbursement" shall have the meaning assigned to it by Section 5.01(d) herein.

1.22 "Key Employee" means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.23 "Nonelective Contribution(s)" means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The manner in which such amounts are applied towards the cost of the Benefit Package Option(s) shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. Except as otherwise provided in Appendix C (or enrollment materials), in no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation if the Employee declines coverage under one or more of the Benefit Package Option(s) offered under the Plan. Any unused Non-Elective Contributions shall be returned to the Employer.

1.24 "Participant" means an Employee who becomes a Participant pursuant to Article II.

1.25 "Plan" means this Flexible Benefits Plan.

1.26 "Plan Administrator" or "Committee" means the person(s) appointed by the Employer with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.27 "Plan Sponsor" means the Employer who maintains the plan, in the case of a single Employer plan. In the case of a plan established or maintained by an Employee organization, the Plan Sponsor is the Employee organization. In the case of a plan established by two or more Employers, or jointly by one or more Employers and one or more Employee organizations, the Plan Sponsor is the Association, Committee Joint Board of Trustees or other group of representatives of the parties who establish or maintain the plan.

1.28 "Plan Year" shall be the twelve month period from October 1 until the following September 30 provided, however, that a period of less than twelve months may be a Plan Year for the Initial Plan Year, the final Plan Year, and a transition period to a different Plan Year. The Initial Plan Year shall be the period October 1, 2003 through September 30, 2004.

1.29 "Pre-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement, before any applicable state and federal taxes have been deducted, for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the premiums attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125,

shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.30 "Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code (other than Sections 106(b), 117, 124, 127, or 132) and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79). Long-term care insurance is not a "Qualified Benefit."

1.31 "Qualifying Employment-Related Expenses" means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.32 "Qualifying Individual" means:

(a) a Dependent of the Participant who is under the age of thirteen (13);

(b) a Dependent of a Participant who is mentally or physically incapable of caring for himself or herself; or

(c) the Spouse of a Participant who is mentally or physically incapable of caring for himself or herself.

1.33 "Qualifying Services" means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.34 "Regular Full-Time or Regular Part-Time Employee" means a regular full-time or regular part-time employee of an Employer (excluding Employees covered under a collective bargaining agreement) as classified by the Employer under its standard personnel practices.

1.35 "Reimbursement Account(s) or Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.20 herein), Dependent Care Reimbursement (as defined in Section 1.11 herein), and Individual Premium Reimbursement (as defined in Section 1.22 herein). No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.36 "Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant enrolls in the specific component Benefit Package Options with Pre-tax Premiums or After-tax Premiums in accordance with Article III. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database.

1.37 "Spouse" means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual legally separated from the Participant under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.38 "Student" means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week and who is eligible for coverage or participation under any of the Benefit Package Options shall be eligible to become a Participant in this Plan on the first of the month following date of hire. Participation in this Plan shall be effective as set forth in Section 3.02 herein. The Eligibility for Benefit Package Option(s) offered under the Plan shall be subject to the additional requirements, if any, specified in the applicable Benefit Package Option. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Package Options.

2.02 Termination of Participation. Participation shall terminate on the earliest of: i) the date an Employee ceases to be an Employee (except as otherwise provided in Section 3.05 for "COBRA coverage"); ii) when an Employee ceases to meet the eligibility requirements of Section 2.01 of this Plan; iii) the date this Plan is amended to exclude the Employee or is terminated; iv) the effective date of the Employee's election not to participate pursuant to Sections 3.03 or 3.04. Subject to any specific limitations for any particular benefit which the Participant has elected: (a) participation shall be continued during a leave of absence for which the Participant continues to receive a salary from his or her employer and (b) participation shall be suspended during an unpaid leave of absence.

2.03 Eligibility to Participate in Reimbursement Accounts. Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week shall become eligible to Participate in the Reimbursement Accounts on the first of the month following date of hire. Participation in the Reimbursement Accounts shall be effective as set forth in Section 3.02 herein. Employees covered under a collective bargaining agreement will only be eligible for Reimbursement Benefits if such benefits are provided for under the agreement.

Please note: FMLA applies to employers with 50 or more employees.

2.04 Qualifying Leave Under Family Leave Act.

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health insurance benefits and HCRA benefits (if offered under the Plan as set forth in Appendix A attached hereto) on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the contribution. An Employer may

elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the contribution shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Redirection basis if that was the method used before FMLA leave.) In the event of unpaid leave (or paid leave where coverage is not required to be continued), a Participant may elect to continue his or her coverage under the Premium Payment and/or Medical Care Reimbursement components during the FMLA leave. If the Participant elects to continue coverage while on leave, then the Participant may pay his or her share of the contribution in one of the following ways: (i) with After-tax Contributions, by sending monthly payments to the Employer by the due date established by the Employer; (ii) with Pre-tax Contributions, by having such amounts withheld from his ongoing Compensation (if any), or pre-paying all or a portion of the contribution for the expected duration of the leave with Pre-tax Contributions. To pre-pay the contribution with Pre-tax Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (Pre-tax Contributions may not be used to fund coverage during the next Plan Year); or (iii) under another arrangement agreed upon between the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return with Pre-tax Contributions or After-tax Contributions). If the Employer requires all Participants to continue coverage during the leave, the Participant may elect to discontinue the Participant's required contributions until the Participant returns from leave. Upon return from leave, the Participant will be required to repay the contribution not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant. If a Participant's coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or otherwise required by the FMLA. Employees whose coverage terminated during the leave may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. Not with standing the preceding sentence, with regard to HCRA benefits, a Participant whose coverage ceased will be entitled to elect whether to be reinstated in the HCRA at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a HCRA coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not make contributions.

(b) Non-Health Benefits. If a Participant goes on qualifying leave under the FMLA,

Entitlement to non-health benefits, such as DCRA (if offered under the Plan as set forth in Appendix A attached hereto), is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 2.05. If such policy permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave be required to repay the contributions not paid by the Participant during the FMLA leave.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not effect eligibility, then the Participant will continue to participate and the contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If a Participant goes on an unpaid leave that affects eligibility, the election changes rules in Section 3.04 will apply. If such policy permits a Participant to discontinue contributions while on leave, the Participant will upon returning from leave be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III
PREMIUM ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-tax Contributions, After-tax Contributions and/ or Benefit Credits (as set forth in Appendix C attached hereto) to fund any Benefit Package Option available under the Plan, provided that only Qualified Benefits (other than group term life insurance coverage in excess of $50,000) may be funded with Pre-tax Contributions.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Cafeteria plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Flexible Benefit Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator during the thirty (30) day period prior to the day the Employee first becomes eligible to participate in this Plan. If an Employee is eligible to participate in this Plan on the date he is first hired, a Salary Reduction Agreement must be completed, signed, and filed with the Plan Administrator within thirty (30) days from the date of hire. Except as provided in Section 3.04(b) (for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption), the elections made by the Participant on this initial Salary Reduction Agreement shall be prospectively effective as of the first pay period coinciding with or immediately following the date that the Salary Reduction Agreement is filed (or if later, the date of the employee's eligibility under the Plan) and, subject to Section 3.04, ending on the last day of the Plan Year in which such participation began. Coverage under the component Benefit Package Options will be effective in accordance with the eligibility requirements contained in such Benefit Package Options.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement with the Plan Administrator in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the "annual election period." An Election shall be made by submitting a Salary Reduction Agreement to the Plan Administrator during the election period, and shall be effective for the entire Plan Year beginning on the Anniversary Date. A Participant or Employee who fails to complete, sign and file a Salary Reduction Agreement as required by this Section 3.03 shall be deemed to have elected to continue the same coverages under the Benefit Package Options funded by the same election (i.e., either Pre-Tax Contributions, After-tax Contributions, or Benefit Credits (as set forth in Appendix C), adjusted to reflect any increase or decrease in premium/cost, then in effect for such Participant or Employee. Notwithstanding the foregoing, annual elections for participation in the HCRA and DCRA must be made by submitting a Salary Reduction Agreement prior to the beginning of each Plan Year -- no deemed elections shall occur under such Plans.

3.04 Change of Benefit Election. A Participant shall not make any changes to the Pre-tax Contribution amount or to the Participant's elected allocation of Benefit Credits, if any, except for election changes permitted under this Section 3.04, and for changes made during the Annual Election Period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

Except as provided in Section 3.04(b) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

(a) *Change in Status*. A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined is Section 1.07), but only if such election change is made on account of and corresponds with a Change in Status which affects eligibility for coverage under a plan of the Employer or a plan of the Participant's Spouse's, or the Participant's Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under an employer's plan includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage. The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status.

Assuming the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Dependent Eligibility.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status.

Notwithstanding the foregoing, if the Participant, the Participant's Spouse or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce).

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the other employer's plan, unless the Employer has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCRA.* With respect to the DCRA (when offered under the Plan), a Participant may change or terminate his or her election upon a Change in Status if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under Code Section 129.

(4) *Special Consistency Rule for Group Term Life Insurance, Disability and Dismemberment Coverage.* For any Change in Status, a Participant may elect either to increase or to decrease group-term life insurance, disability

coverage, or accidental death and dismemberment coverage offered under the Plan.

(b) *HIPAA Special Enrollment Rights.* If a Participant, a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Section 9801(f) of the Code, then a Participant may revoke a prior election for group health plan coverage and make a new election (including an election for Health Care Reimbursement Account) provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

(1) A Participant or Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

(2) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

(c) *Certain Judgments, Decrees and Orders*. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage (including an election for Health Care Reimbursement) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (i) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage), or (ii) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(d) *Medicare and Medicaid*. If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health

or accident coverage (including an election for Health Care Reimbursement) of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage (including an election for Health Care Reimbursement) of that individual who loses Medicare or Medicaid eligibility.

(e) *Change in Cost*

The following rules are not applicable to Health Care Reimbursement Accounts under the Plan.

For purposes of this Section 3.04(e), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide coverage for major medical are considered to be similar coverage. For purposes of this definition, a HCRA is not similar coverage with respect to an accident or health plan that is not a HCRA. This Plan may, in the Plan Administrator's discretion, treat coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing salary reductions or decreasing cash-out amounts, if applicable) to reflect insignificant increases in their required contribution for their Benefit Package Option(s) and decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator in its sole discretion on a uniform and consistent basis will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases*. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Plan Year, the Participant may either (i) make a corresponding prospective increase in his or her elective contributions (by increasing salary reductions or decreasing cash-out amounts, if applicable), (ii) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage, or (iii) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, on a uniform and consistent basis, whether a cost increase is significant.

(3) *Significant Cost Decreases*. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Plan Year, the Plan Administrator may permit the following election changes:

(i) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect Benefit Package Option that has decreased in cost, and (ii) Employees who are otherwise eligible under Section 2.01 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance and on a uniform and consistent basis, whether a cost decrease is significant.

(4) *Limitation on Change in Cost Provisions for DCRA*. The above "Change in Cost" provisions (Sections 3.04(e)(1) – 3.04(e)(3)) apply to DCRA *only* if the cost change is imposed by a dependent care provider who is not a "relative" of the employee. For this purpose, a relative is an individual who is related as described in Code Section 152(a)(1) through (8), incorporating the rules of Section 152(b)(1) and (2).

(f) *Change in Coverage*

The following rules are not applicable to Health Care Reimbursement Accounts under the Plan.

The definition of "similar coverage" under Section 3.04(e) also applies to this Section 3.04(f).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined in subsection (i) below) Participants may elect similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below) Participants may drop coverage if no similar coverage is available. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, on a uniform and consistent basis, whether a curtailment is "significant", and whether a Loss in Coverage has occurred.

(i) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under an accident or health plan) during a Plan Year, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage. Coverage under a plan is deemed

"significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(ii) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Plan Year, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage, or drop coverage if no other Benefit Package Option providing similar coverage is available.

(iii) For purposes of this Section 3.04(f)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant, Participant's Spouse or Dependent resides, or a Participant, Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its discretion, *may* treat the following as a Loss of Coverage:

a. a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred provider network or an HMO).

b. a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant, the Participant's Spouse or the Participant's Dependent is currently in a course of treatment; or

c. any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If, during a Plan Year, the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (i) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly added or significantly improved Benefit Package Option, and (ii) Employees who are otherwise

eligible under Section 2.01 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance and on a uniform and consistent basis, whether there has been an addition or a significant improvement of a Benefit Package Option.

(3) *Loss of Coverage Under Other Group Health Coverage*. A Participant may prospectively change his or her election to add group health coverage for the Participant, the Participant's Spouse, or the Participant's Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in section 7701(a)(4)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (ii) the Plan permits Participants to make an election for a Plan Year which is different from the plan year under the other cafeteria plan or qualified benefits plan. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the other employer plan.

Any change in an election affecting Reimbursement Accounts pursuant to this Section also will change the maximum reimbursement for the period of coverage remaining in the Plan Year. Such maximum reimbursement for the period of coverage following an election change shall be calculated by adding the balance (if any) remaining in each of the Participant's Reimbursement Accounts as of the end of the portion of the Plan Year immediately preceding the change in election, to the total Plan Contributions scheduled to be made by the Participant during the remainder of such Plan Year to such Account(s) (except for any maximum Individual Premium Reimbursement).

An Employee who is eligible to become a Participant but declined to become a Participant during the initial election period pursuant to Section 3.02(a) or (b) may become a Participant and file a Pre-tax Contribution election within thirty (30) days of the occurrence of an event described in Section 3.04 above, but only if the election under the new Salary Reduction Agreement is made on account of and corresponds with the event (as described above). A Participant otherwise entitled to make a new election under this Section must do so within thirty (30) days of the event (e.g., Change in Status, significant change in cost or coverage, Medicare or Medicaid eligibility, special enrollment right or judgment, decree, or order).

Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Except as otherwise provided in the applicable Benefit Package Options, former Participants who are rehired within thirty (30) days or less of the date of termination of employment will be reinstated with the same election(s) such individual had before termination. If a former Participant is rehired more than thirty (30) days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election.

ARTICLE IV
PREMIUM PAYMENTS AND CREDITS AND DEBITS TO ACCOUNTS

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Package Options shall be funded by Participant's Pre-tax and/or After-tax Contributions, Benefit Credits, if provided for in Appendix C attached hereto, and any Nonelective Contributions. The component Benefit Package Options, and required contributions thereunder, shall be made known to employees in enrollment materials:

(a) **Participant After-tax and/or Pre-tax Contributions.** Pre-tax or After-tax Contributions (as elected by the Employee) shall equal the contributions required from the Participant (less any Benefit Credits allocated thereto by the Participant, if provided for in Appendix C, or Nonelective Contributions allocated thereto by the Employer) for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Package Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus Benefit Credits, if any, and Nonelective Contributions shall not exceed the aggregate cost of the benefits elected.

(b) **Benefit Credits.** The Employer may, but is not required to, make available to Participants Benefit Credits to apply, at the Participant's discretion, towards the cost of one or more of the Benefit Package Options chosen by the Participant. Benefit Credits will be available as set forth in Appendix C.

(c) **Nonelective Contributions**. The Employer may, but is not required to, contribute Nonelective Contributions on behalf of each Participant for the purpose of providing one or more of the Benefit Package Options under the Plan. Nonelective Contributions will be provided as set forth in the enrollment material.

4.02 Allocations Irrevocable During Plan Year. Except as provided in Sections 3.04, 3.05, and 4.03, neither (a) the insurance coverages nor the Pre-Tax Contribution amounts withheld, therefore elected, under Section 5.01(a), nor (b) the amount to be credited to a Participant Account during the Plan Year pursuant to Sections 4.04 and 4.05, nor (c) the allocation of such amounts to the appropriate Account(s) of the Participant, can be changed during the Plan Year.

4.03 Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly

situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

4.04 Health Care Reimbursement.

(a) **Debiting and Crediting of Accounts**. Each Participant's HCRA (if provided for in Appendix A) will be credited with amounts withheld from the Participant's Compensation for Health Care Reimbursement and any Benefit Credits (if any) allocated thereto pursuant to the Salary Reduction Agreement and any Nonelective Contributions allocated thereto by the Employer, if any. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount which a Participant has had credited to his HCRA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses or any use that is permitted within the applicable Department of Labor or Internal Revenue Service regulations.

(b) **Source of Payments.** All Health Care Reimbursements derived hereunder shall be paid exclusively from the amounts in each Employee's HCRA funded by amounts withheld from the Employee's Compensation pursuant to the Salary Reduction Agreement for Health Care Reimbursement, any Benefit Credits allocated thereto (if any), and any Nonelective Contributions allocated specifically by the Employer for Health Care Reimbursement (if any). In the event that an Employee's claim for Health Care Reimbursement benefits exceeds the amount currently available in the Employee's HCRA, the Employer shall pay the excess amount up to the amount elected by the Participant on the Salary Reduction Agreement for Health Care Reimbursement less any reimbursements already disbursed. Future premium payments by the Employee shall then go to the Employer as reimbursement for the money so advanced on behalf of the Employee.

(c) **Employer Risk**. If the Employee terminates employment before the Employer has been reimbursed for the money it has advanced on behalf of the Employee, the entire unreimbursed portion shall be deemed to be an "administrative expense" to be refunded to the Employer by any unused Account balance(s) (if any) as provided in Section 4.04(a).

4.05 Dependent Care Reimbursement.

(a) **Crediting and Debiting of Accounts**. Each Participant's DCRA (if provided for in Appendix A) will be credited with amounts withheld from the Participant's Compensation for Dependent Care Reimbursement and any Benefit Credits (if any) allocated thereto, pursuant to the Salary Reduction Agreement, and Nonelective Contributions allocated thereto by the Employer, if any. The Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months (within the same Plan Year), to be paid out as the DCRA balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the DCRA for any Plan Year. Any amount allocated to the DCRA shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative costs or any use that is permitted within the applicable Internal Revenue Service regulations.

(b) **Source of Payments**. All Dependent Care Reimbursement benefits derived hereunder shall be paid exclusively from the amounts in each Employee's Dependent Care Reimbursement Account funded by amounts withheld from the Employee's Compensation pursuant to the Salary Reduction Agreement for Dependent Care Reimbursement, any Benefit Credits allocable thereto, and any Nonelective Contributions provided by the Employer specifically for Dependent Care Reimbursement Benefits.

4.06 Individual Premium Reimbursement.

(a) **Crediting and Debiting of Accounts.** Each Participant’s Individual Premium Reimbursement Account (“IPR Account”) will be credited with amounts withheld from the Participant’s Compensation for Individual Premium Reimbursement pursuant to the Salary Reduction Agreement. The Account will be debited for Individual Premium Reimbursements disbursed to the Participant in accordance

with Article V of this document. In the event that the amount in the IPR Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months (within the same Plan Year), to be paid out as the IPR Account balance becomes adequate. In no event will the amount of Individual Premium Reimbursements exceed the amount withheld pursuant to the Salary Reduction Agreement for any Plan Year. Any amount credited to the IPR Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide Individual Premium Reimbursement for the Plan Year within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative costs.

(b) **Source of Payments.** All Individual Premium Reimbursement benefits derived hereunder shall be paid exclusively from the amounts in each Employee's IPR Account funded by amounts withheld from the Employee's Compensation pursuant to the Salary Reduction Agreement for Individual Premium Reimbursement.

ARTICLE V
BENEFITS

5.01 Qualified Benefits. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Insurance Premium Payments under 5.01(a); ii) the maximum Health Care Reimbursement under 5.01(b) (if provided for in Appendix A); iii) the maximum Dependent Care Reimbursement under 5.01(c) (if provided for in Appendix A), and the iv) the maximum amount of Individual Premium Reimbursement Benefit under 5.01(d) (if provided for in Appendix A). The Qualified Benefits available for election are one or more of the following:

(a) **Insurance Premium Payment.** The Employer shall withhold from a Participant's Compensation an amount equal to the contributions required from the Participant (less any applicable Benefit Credit and/or Nonelective contribution, if any) for coverage of the Participant, or the Participant's Spouse or Dependents, under the Benefit Package Options elected by the Participant. The benefits are subject to the terms and conditions of the applicable Benefit Package Options which are incorporated herein.

(b) **Health Care Reimbursement**. If provided for in Appendix A, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents while he is an Employee, during the Plan Year for which the Participant's election is effective. These expenses must also be expenses which --

(l) are not covered, paid or reimbursed from any other source; and

(2) meet the criteria of tax deductibility as a medical or dental expense under Section 213 of the Code, as amended and the regulations thereunder, and

(3) will not be taken as a deduction from income on the Participant's federal income tax return in any tax year; and

(4) do not exceed the amount that the Employee has elected to have credited (pursuant to the applicable method(s) described in Section 4.01 herein) to a HCRA for Health Care Reimbursement for the Plan Year (or the maximum reimbursement amount of $2,400 if lesser) less previous Health Care Reimbursements made during the Plan Year. The minimum amount an Employee who elects Health Care Reimbursement Benefits may elect to have credited to a Health Care Reimbursement Account for a Plan Year is $180. For the initial Plan Year, October 1, 2003 through September 30,

2004, the maximum reimbursement amount shall be the amount elected to be credited to an Account or $2,400, whichever is lesser; and

(5) are verified in writing to the satisfaction of the Administrator that a covered expense has occurred and the claims for which meet the substantiation requirements of Section 6.10.

(c) **Dependent Care Reimbursement.** If provided for in Appendix A, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him or her while an Employee, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6.10 have been complied with. No payment otherwise due a Participant hereunder shall exceed the smallest of:

(1) the Participant's Earned Income for the applicable month; or

(2) the Earned Income of the Participant's Spouse for such month (Note: a Spouse of a Participant who is not employed during a month in which the Participant incurs Eligible Employment Related Expenses and who is either incapacitated or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Eligible Employment Related Expense(s), and $500 per month for two or more Qualifying Individuals); or

(3) the amount the Participant has elected to have credited to a Dependent Care Reimbursement Account (pursuant to an applicable method(s) described in Section 4.01 herein) for Dependent Care Reimbursement for the Plan Year less any prior Dependent Care Reimbursements during the Plan Year; or

(4) Five Thousand Dollars ($5,000), ($180 minimum per Plan Year), or, if the Participant is married and files a separate tax return, Two Thousand Five Hundred Dollars ($2,500) (or any future aggregate limitations promulgated under Code Section 129) less any prior reimbursements during the Plan Year.

(d) **Individual Premium Reimbursement**. If provided for in Appendix A, payment shall be made to the Participant in cash as reimbursement for Eligible Individual Premium Expenses incurred by the Participant or his Dependents while he is an Employee during the Plan Year for which the Participant’s election is effective, provided that the substantiation requirements of Section 6.10 herein have been satisfied. The amounts reimbursed to the Participant shall not exceed the amount

that the Employee has elected to have withheld from Compensation for Eligible Individual Premium Expenses for the Plan Year.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions and/or Benefit Credits may not be received in the form of cash compensation, except as otherwise provided for in Appendix C.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses, Eligible Employment Related Expenses, and/or Eligible Individual Premium Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.10 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Benefits. Coverage under the HCRA, DCRA, and/or IPR Account shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however that Participants may submit claims for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until ninety (90) days after the end of the Plan Year for which the election had been in effect, and to receive reimbursement hereunder. Participants in the HCRA and the IPR Account may submit claims for reimbursement for Eligible Medical Expense arising during the Plan Year and before the date of separation from service at any time until ninety (90) days after the end of the Plan Year for which the election had been in effect, and to receive reimbursement hereunder. Unless a COBRA election is made, Participants shall not be entitled to receive reimbursement for Medical Care expenses incurred after coverage ceases under this Section. Any unused reimbursement benefits at the expiration of the ninety (90) days period following the close of the Plan Year shall be treated in accordance with Sections 4.04 or 4.05, and 4.06.

5.05 COBRA Coverage. Each Benefit Package Option made available under Article V that is considered to be a "group health plan" under Code Section 4980B, because employees and their families are provided with health care benefits within the meaning of Code Section 213(d)(1), including the HCRA, shall contain the necessary provisions required by Code Section 4980B, to ensure that such benefits may be continued on or after the occurrence of the qualifying events defined in Code Section 4980B(f)(3).

5.06 Coordination of Benefits Under HCRA. The HCRA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be

considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI
PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors (or an authorized officer of the Employer) appoints a Committee (the Plan Administrator) which keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the Summary Plan Description issued in connection with the Plan. In the case of an insured Benefit Package Option, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan;

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions;

6.02 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

6.05 Bonding. Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses. All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

6.07 Funding Policy. The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this plan. Such limitation shall include, but not be limited to, losses or obligations which pertain to the following:

(a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;

(c) The Employer will not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the

time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

(d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

6.08 Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.09 Indemnification. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

6.10 Substantiation of Expenses. Each Participant must submit a written or electronic Claim Form to the Plan Administrator to receive reimbursements from his HCRA or DCRA or for his Eligible Individual Premium Expenses (the written claim form will be provided by the Plan Administrator), accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. With respect to Eligible Individual Premium Expenses, each Participant must submit a written statement/invoice from the insurance carrier stating that (i) the coverage under the individual insurance policy was in effect during the period for which reimbursement is being requested and (ii) the Eligible Individual Premium Expenses for which reimbursement is requested have been paid. The forms shall contain such evidence as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

6.11 Reimbursement. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator. Year-end expense reimbursement claims must be submitted to the Plan Administrator within ninety (90) days of the close of the Plan Year for which the Salary Reduction Agreement is effective, and during which such expense was incurred, in order to be eligible for reimbursement. Likewise, if a Participant terminates participation in the Plan with a credit balance in any Reimbursement Account, such Participant shall be entitled to submit to the Plan Administrator any claims for reimbursement for reimbursable expenses incurred prior to such cessation of Participation at any time within ninety (90) days after the close of the Plan Year for which the Salary Reduction Agreement is effective.

6.12 Statements. The Plan Administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care and/or Dependent Care Reimbursement and the respective Reimbursement Account balance(s).

ARTICLE VII
FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the Department of Labor ("D.O.L.") taking into consideration any enforcement procedures adopted by the D.O.L.

ARTICLE VIII
CLAIMS PROCEDURES

8.01 Application to Plan Benefits. This Article shall not apply to benefits under the component Benefit Package Options, but shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under this Cafeteria Plan document). This Article shall be the claims procedure applicable to the Health Care Reimbursement and the Dependent Care Reimbursement Plan(s).

8.02 Procedure if Benefits Are Denied Under the Plan. Any Employee, beneficiary, or his duly authorized representative may file a claim for a benefit to which the claimant believes that he is entitled. Such a claim must be in writing and delivered to the Plan Administrator or its designee in person or by mail, postage paid in accordance with the terms of this Plan. Within thirty (30) days after receipt of such claim, the Plan Administrator or its designated claims administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless, for reasons beyond the control of the Plan Administrator or its designee, an extension of time for processing the claim is required. In no event may the extension exceed fifteen (15) days from the end of the initial thirty (30) day period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 30-day period. If an extension of time is necessary because the claimant failed to provide sufficient information necessary to decide the claim, the notice of the extension shall describe the required information and the claimant shall have forty-five (45) days from the receipt of such notice to provide the required information. The time period for making a determination is suspended until the earlier of the date the claimant provides the required information or the end of the 45 day period, whichever is earlier.

8.03 Requirement for Written Notice of Claim Denial. A written notice shall be provided to every claimant who is denied a claim for benefits under this Plan. Such written notice shall set forth in a manner calculated to be understood by the claimant the following information:

(a) The specific reason or reasons for the denial;
(b) Specific reference to pertinent Plan provisions on which the denial is based;
(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and
(d) An explanation of the Plan's claim review procedure.
(e) With respect to a claim for benefits filed under the Plan (except for Dependent Care Expense Reimbursement Benefits and issues germane to the Cafeteria Plan), a statement informing the claimant that they may have a right to bring suit in federal court in accordance with ERISA Section 502(a) following an adverse benefit determination on review by the Plan Administrator (as described in 8.04 and 8.05 below).

(f) A statement indicating that the claimant shall be provided, 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.
(g) A statement indicating that the claimant may request a copy of any internal rule, guideline or protocol relied upon in making the determination.
(h) Any other information required by federal law.

8.04 Right to Request Appeal of Benefit Denial. Within 180 days after the receipt by the claimant of written notification of the denial (in whole or in part) of his claim, the claimant or his duly authorized representative may make a written application to the Plan Administrator or its designee (as indicated in the denial notice described in Section 8.03 herein), in person or by certified mail, postage prepaid, to be afforded an appeal of such denial. If there are two levels of appeal required by the Plan Administrator (as indicated in the notice of denial), a claimant must request a second review within a reasonable amount of time following a denial of the first level appeal (as set forth in the denial notice). As part of the review process upon appeal (whether one level of appeal or two levels of appeal), the claims reviewer shall:

(a) Provide the claimant the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits;

(b) Provide that the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits (including the identity of all medical experts utilized in the determination process, whether relied upon or not);

(c) Provide for a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claimant's claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal or the subordinate of such individual;

(e) Provide that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator or its designee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional may not be 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;

8.05 Disposition of Disputed Claims. The decision on appeal shall be made not later than sixty (60) days after receipt of a request for a review. If there are two levels of appeal established under the Plan, then the decision following the first request for appeal will be made not later than 30 days following receipt of the request for the review. The decision following the second request for an appeal will be made within 30 days after receipt of the request of appeal. Regardless of whether there are one or two levels of appeal, the Plan Administrator is the claim fiduciary responsible for making the final claims determination under the Plan.

8.06 Requirement for Written Notice of Claim Denial Upon Appeal. The Plan Administrator or its designee shall provide a written notice to every claimant who is denied a claim for benefits in accordance with Section 8.05 herein. Such written notice shall set forth, in a manner calculated to be understood by the claimant, the information set forth in Section 8.03 herein.

ARTICLE IX
AMENDMENT OR TERMINATION OF PLAN

9.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Committee (see Section 1.06) in accordance with its normal procedures for transacting business or by written consent of all Committee members. Such amendments may apply retroactively or prospectively. Each Benefit Package Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Board of Directors (or a duly authorized officer of the Employer) in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine. Subject to Sections 4.04(a), 4.05(a), and 4.06(a) (if applicable), no amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance nor its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries.

ARTICLE X
GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of Texas to the extent not preempted.

10.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Non-Alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

10.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 Inability to Locate 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 he 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 shall be forfeited after a reasonable time after the date any such payment first became due.

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from

time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 Tax Effects. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

10.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 Incorporation by Reference. The actual terms and conditions of the separate component Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

10.14 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

10.15 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

10.16 Forfeiture of Unclaimed Reimbursement Account Benefits. Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

10.17 HIPAA Privacy with respect to Health FSA

(a) The Health FSA (the "Plan") will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the Privacy Notice distributed to Plan Participants.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions in Subsection b below.

(b) With Respect to PHI, the Plan Sponsor agrees to certain conditions.

The Employer agrees to:

- Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Report to the Plan any PHI use or disclosures provided of which it becomes aware; Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures; Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer

needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

(c) Adequate separation will be maintained between the Plan and the Plan Sponsor. Only the individuals identified in the Privacy Notice distributed to Participants in accordance with HIPAA may have access to PHI. The persons described in the Privacy Notice may only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described herein do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(d) This section 10.17 shall be effective as of April 14, 2003 or such applicable later date as set forth in HIPAA and the applicable regulations issued thereunder.

ARTICLE XI
CONTINUATION COVERAGE UNDER COBRA

The following provisions shall be applicable to the HCRA, and any other group health plan (as defined by Code §§ 4980B and 5000(b)(1) and the regulations promulgated thereunder) subject to COBRA that does not otherwise contain COBRA provisions. As noted in Section 11.05, COBRA coverage need not be extended to certain HCRA Participants. The intent of this Article is to extend continuation rights required by COBRA. To the extent greater rights are provided for hereunder, this Article shall be void.

11.01 Continuation Coverage after Termination of Normal Participation. During any Plan Year during which the Employer is subject to Code Section 4980B (COBRA) or 38 U.S.C. Section 4301 et seq. (Uniformed Services Employment and Reemployment Rights Act or "USERRA"), each person who is a Qualified Beneficiary described in Section 5.02 herein shall have the right to elect to continue coverage under the Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the plan is known as "Continuation Coverage."

11.02 Who is a "Qualified Beneficiary." A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event, covered under the group health plan and is (a) an Employee of the Employer, including persons who are considered to be "employees" within Code Section 401(c), directors and independent contractors (such persons are called "Covered Employees"), (b) the Spouse of the Covered Employee, or (c) a Dependent of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee's employment. A child born to or placed for adoption with a Covered Employee during Continuation Coverage will also be a Qualified Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary".

11.03 Who is not a "Qualified Beneficiary." A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Health Care Reimbursement Plan (or other group health plan subject to COBRA) by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 11.08, below, shall not be considered to be a Qualified Beneficiary.

11.04 What is a "Qualifying Event." Any of the following shall be considered as a "Qualifying Event":

(a) death of a Covered Employee;

(b) termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;

(c) divorce or legal separation of a Covered Employee from the employee's Spouse;

(d) a Covered Employee becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act; or

(e) a dependent child of a Covered Employee ceasing to be a Dependent.

(f) a military leave of absence lasting 31 days or longer.

In the case of any person treated as a "Covered Employee" but who is not a common-law employee, termination of "employment" means termination of the relationship that originally gave rise to eligibility to participate in the Health Care Reimbursement Plan (or other group health plan subject to COBRA).

11.05 COBRA Not Applicable to Certain HCRA Participants. In accordance with IRS regulations, COBRA continuation coverage will not be offered to HCRA participants under certain circumstances:

(a) **Unavailability of COBRA in Subsequent Plan Years**. COBRA continuation will not be offered to a HCRA Participant in any Plan Year following the Plan Year in which the Qualifying Event occurs if:

(i) **HCRA is Exempt from HIPAA.** The HCRA is exempt from HIPAA (i.e., a major medical plan is available in addition to the HCRA, and the HCRA benefit does not exceed two times the salary reduction or, if greater, the salary reduction plus $500); and

(ii) **COBRA Premium Equals or Exceeds HCRA Benefit.** If for the plan year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of HCRA COBRA coverage equals or exceeds the maximum benefit available to the Qualified Beneficiary for the plan year.

(b) **Unavailability of COBRA in Plan Year in which Qualifying Event Occurs.** COBRA continuation coverage will not be offered to a Qualified Beneficiary in the Plan Year in which the Qualifying Event occurred if:

(i) **Conditions in 11.05(a) are Satisfied.** The HCRA satisfies the conditions set forth in Section 11.05(a); and

(ii) **Participant's Reimbursement Account Has a Deficit at the Time of the Qualifying Event.** Taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining HCRA balance for the Plan Year is less than the maximum required COBRA premiums for the rest of the year -- i.e., the Participant's Reimbursement Account is in a deficit position.

The Plan Administrator will notify HCRA Participants as to their COBRA eligibility (if any).

11.06 What Benefit is Available under Continuation Coverage. Each person who is eligible to elect to continue coverage under Article XI shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event (or a lesser level of coverage). A premium for Continuation Coverage shall be charged to Employees and Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by applicable law.

11.07 Notice Requirements.

(a) When an Employee becomes covered under this HCRA (or any other group health plan subject to COBRA), the Plan Administrator must inform the Participant (and Spouse, if any) in writing of the rights to continued coverage, as described in Article XI.

(b) The Employer shall give the Plan Administrator (if different from the Employer) written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.

(c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the HCRA (or any other group health plan subject to COBRA), as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Section 4980B, in accordance with the terms of this Plan.

(d) In the case of a Qualifying Event described in Section 11.04(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the later of the occurrence thereof or the date coverage is lost as a result of the occurrence thereof. The Plan Administrator shall give written notification of Conversion Coverage rights to any other affected Qualified Beneficiaries within fourteen (14) days of receipt of the notice described in this Section 11.07(d).

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

11.08 Election Period. Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the later of the date of the notice required by Section 11.07 or the date coverage terminates as a result of the Qualifying Event in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

11.09 Duration of Continuation Coverage. Except as otherwise provided in this Plan, Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ceased due to occurrence of the initial Qualifying Event described in Section 11.04(b), unless during such 18-month period a subsequent Qualifying Event occurs, in which case, another election to extend coverage for 18 months shall be available to the Beneficiary. Except as otherwise provided in this Section, in the case of a Qualifying Event not described in Section 11.04(b), Continuation Coverage shall extend for a period of 36 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event. In the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled within 60 days of a Qualifying Event, described in Section 11.04(b), Continuation Coverage with respect to such event shall extend for a period of 29 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event if the Qualified Beneficiary has provided notice of such determination within sixty (60) days after the date of such determination and before the end of the initial 18 month Continuation Coverage period. In the event a Covered Employee becomes entitled to Medicare coverage, the period of Continuation Coverage for a Qualified Beneficiary, other than the Covered Employee for such Qualifying Event or any subsequent Qualifying Event, shall not terminate for a period of 36 months from the date the Covered Employee becomes entitled to Medicare benefits. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

11.10 Automatic Termination of Continuation Coverage. Continuation Coverage shall automatically cease if (a) the Employer no longer offers the particular group health coverage to any of its employees (b) the required premium for Continuation Coverage for a particular coverage is not paid within 30 days of the date due or within 45 days after the initial election of Continuation Coverage made pursuant to Section 11.08 (whichever is later), (c) an electing Qualified Beneficiary becomes covered under another group health plan other than a group health plan which may limit a Qualified Beneficiary's coverage because it involves a pre-existing condition except for continuation coverage arising from a Qualifying Event described in 11.04(f), or (d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare except for continuation coverage arising from a Qualifying Event described in 11.04(f). For individuals on Military leave, Continuation Coverage may commence prior to the end of the 18 month period if the Employee fails to return to work in accordance with USERRA or the Employee loses his rights under USERRA as a result of the Employee's conduct.

IN WITNESS WHEREOF, the Employer has executed this Cafeteria Plan as of the date set forth below.

MCGREGOR INDEPENDENT SCHOOL DISTRICT

By:_____

Title:_____

Date:_____

APPENDIX A
BENEFIT PACKAGE OPTIONS

List of Benefit Package Options and Employee Contribution Requirements
(See Sections 1.05 and 4.01)

1. Premium Expense Account

2. Health Care Reimbursement Account

3. Dependent Care Reimbursement Account

APPENDIX B
AFFILIATED EMPLOYERS ADOPTING THE PLAN

The following is a list of Affiliated Employers (as defined in 1.01 of the Plan) adopting the Plan. (See Sections 1.01)

1. None Affiliated

APPENDIX C
BENEFIT CREDITS AND OR CASH BENEFITS

A. CASH BENEFITS

1. *Opt-out Option*: Additional taxable compensation for certain Employees who opt-out of certain Benefit Package Options (as described in the enrollment materials) is not offered under the Plan. The amount available under the Opt Out Option shall be set forth in the enrollment materials.

2. *Cash Option*. Additional taxable compensation equal to all or a portion of the Benefit Credits or Nonelective Contributions that exceed the cost of the Benefit Package Option(s) selected by the Participant is not offered under the Plan. The available Cash Option amount will be set forth in the enrollment materials.

B. BENEFIT CREDITS

The Employer may, as indicated below, provide Benefit Credits (as defined in Section 1.04 herein) to each Participant to apply, at the Participant's discretion, towards the cost of one or more of the Benefit Package Options available under the Plan. Benefit Credits, if selected below, are in addition to any Nonelective Contributions (as defined by the Plan) made by the Employer on behalf of each Participant.

Benefit Credits will not be provided under this Plan.

MCGREGOR INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

MCGREGOR INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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MCGREGOR INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

McGregor Independent School District (the "Employer") is pleased to sponsor an employee benefit program known as the Flexible Benefits Plan (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different insurance and fringe benefit programs ("Benefit Package Options") according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary reduction arrangement instead of a corresponding amount of your regular pay. To the extent provided for in the Plan Information section, you may be able to apply Employer provided "Benefits Credits" toward the cost of your benefits. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your Salary Reduction. Alternatively, to the extent described in your enrollment materials, you may choose to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description and the attached Plan Information Summary (collectively, the SPD) describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Summary Plan Description is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between the official plan documents and the Summary Plan Description, the plan documents will govern.

The effective date of this Summary Plan Description is October 1, 2003 and supercedes all other Summary Plan Descriptions for the Flexible Benefits Plan.

PART I

General Information about the Cafeteria Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to choose one or more of the Benefit Package Options offered through the Plan, and enable them to pay for the selected coverage(s) with pre-tax dollars and/or benefit credit dollars (if provided for in the Plan Information Summary and/or the enrollment material).

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's pre-tax options by filling out any required enrollment form(s) for the component Benefit Package Option(s). To the extent listed in the Plan Information section at the back of this SPD, the Plan may also permit you to select Health Care Reimbursement (described in Part II of this SPD), or Dependent Care Reimbursement (described in Part III of this SPD), on a pre-tax basis. The Plan currently enables you to purchase the following Benefits Package Options on a pre-tax basis.

Premium Expense Account
Health Care Reimbursement Account
Dependent Care Reimbursement Account

For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each of the above Benefit Package Options. Ask the Plan Administrator for copies. The plan summaries for Health Care Reimbursement Account and the Dependent Care Reimbursement Account, if provided for in the Plan Information Summary, is provided herein.

Q-3. Who can participate in the Plan?

Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week and who is eligible for coverage or participation under any of the Benefit Package Options shall be eligible to participate in this Plan on the first of the month following date of hire. Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until he or she: i) elects not to participate in accordance with Q-7; or ii) is no longer eligible under the terms of the Plan or employed by the Employer, or Continuation Coverage (as described below) is no longer in effect.

Q-4. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Monthly Savings: $31.00

Q-5. How do I become a participant?

You become a Participant by signing an individual Salary Reduction Agreement on which you elect one or more of the Benefit Package Options available under the Plan, as well as agree to a salary reduction to pay for those Benefit Package Options so elected. You will be provided a Salary Reduction Agreement when you first become eligible to participate. You must complete the form and turn it in to the Human Resources Office within the time period specified by the Plan Administrator. If you are eligible on the Effective Date of the Plan, you will be able to enter the Plan during the Initial Enrollment Period and shall become a Participant on the Effective Date. Otherwise, you will be able to enter the Plan on the effective date of your coverage under the component Benefit Package Options.

In future years, a new Salary Reduction Agreement will be made available to you by the first day of the Annual Enrollment Period, and you will be given the opportunity to confirm or change your choices made for the previous 12-month period for the coming 12 months beginning on the first day of the next Plan Year. This twelve month period is called the "Plan Year". A Participant who fails to complete, sign and file a Salary Reduction Agreement as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and

(except for a Change in Status) will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Health and Dependent Care Reimbursement Accounts must be made by submitting a salary reduction agreement prior to the beginning of each plan year - no deemed elections shall occur with respect to such benefits.

Q-6. What are the enrollment periods for entering the Plan?

When first hired, you must enroll within the time period specified by the Plan Administrator (the "Initial Enrollment Period"). Generally, the Initial Enrollment Period is a 30 day period ending before your eligibility date, unless you are eligible on your date of hire. If you are eligible on your date of hire, the Initial Enrollment Period is generally a period ending 30 days after your date of hire. After the Initial Enrollment Period, you may enroll or change your previous elections during the Annual Enrollment Period. The Annual Enrollment Period will generally begin at least 30 days before the Anniversary Date, (October 1), and end on the Anniversary Date. In the case of the Initial Plan Year, the Enrollment Period will begin at least 30 days before the beginning of the Initial Plan Year, November 1, 1988.

Q-7. Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in Plan or vary the pre-tax salary reductions and/or benefit credits (if provided for in attached Plan Information Summary and/or the enrollment material) you have elected during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections for Pre-Tax Premiums only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator within 30 days of any of the following events:

1. **Change in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse),
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),

- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student),
- a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for Dependent Care Reimbursement Accounts, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health Care Reimbursement benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or a Dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Benefits*. With respect to the Dependent Care Reimbursement benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election

to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* For group term life insurance, disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan *significantly* increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to the Health Care Reimbursement Account under the Plan.)

> Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The

Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Health Care Reimbursement Account under the Plan.)

Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

Q-8. How are my Premium Payments made?

When you become a Participant, your premiums will be paid with that portion of gross income that you have elected to forego through pre-tax salary reduction. You may also pay your premiums with Benefit Credits (if available as provided for in the attached Plan Information Summary and/or in the enrollment material). Benefit Credits are amounts provided by the Employer that you may apply towards the cost of the benefits that you elect. The manner in which you may apply the Benefit Credits, if any, will be set forth in the Plan Information Summary and/or the enrollment material. A portion of the cost of your coverage may also be paid with nonelective employer contributions ("Nonelective Contributions"). Nonelective Contributions are amounts provided by the Employer that are specifically designated for a particular benefit or benefits. The Employer will not be liable to you if an insurance company fails to provide any of the insurance benefits described above. Also, your insurance will end when: you leave employment (unless you make arrangements directly with the insurance carrier to continue coverage); you are no longer eligible under the terms of any insurance policy; or the Employer terminates the insurance plan.

Q-9. What if I terminate my employment during the Plan Year?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See the insurance booklets for information on your right to continued or converted coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

Q-10. Will I have any administrative costs under the Plan?

The Employer is currently bearing the entire cost of administering the Plan.

Q-11. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-12. What happens if my claim for benefits is denied?

If your claim for benefits under one of the Benefit Package Options offered under the Plan (other than HCRA and/or DCRA) is denied, you should proceed under the claims appeal procedures established for that particular Benefit Package Option (see the applicable summary plan description for that Benefit Package Option for more information on the applicable claims procedures). However, if you are denied a benefit under the premium payment portion of this Plan (e.g. a change in status election, eligibility to participate) or under the HCRA or DCRA, you should proceed under the following claims review procedures.

Step 1: *Notice is received from third party administrator.* If your claim is denied, you will receive written notice from the third party administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the third party administrator, the third party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures (including whether the Plan has established one or two levels of appeal);
d. a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision of the third party administrator, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of review, you should file your first appeal with the third party administrator at the address indicated in the notice of denial. The notice of denial reference

in Step 1 above will indicate whether the plan has one or two levels of appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any new information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the third party administrator. Otherwise, notice of the denial will be sent no later than 60 days after the Plan Administrator receives the appeal.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6 (only if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the third party administrator's decision, you may file a second level appeal with the Plan Administrator.* If you still do not agree with the third party administrator's decision, you may file a written appeal with the Plan Administrator within a reasonable period of time described in the notice of denial after receiving the first level appeal denial notice from the third party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-13. What is Continuation Coverage and how does it work?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would

otherwise end. These rules apply to the HCRA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

When Coverage May Be Continued

If you are a participant in the HCRA, then you have a right to choose continuation coverage under the HCRA if you lose your coverage because of:

- a reduction in your hours of employment; or
- a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- the death of your spouse;
- a voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- the divorce or legal separation from your spouse;

In the case of a Dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- the death of the employee;
- a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- his or her parents' divorce or legal separation; or
- he or she ceases to be a dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called “Qualified Beneficiaries”

Type of Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the HCRA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator (or its COBRA Administrator identified in the Plan Information Appendix) is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

An employee or covered dependent is responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result

in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- the contribution for your continuation coverage is not paid on time or it is insufficient (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);

- the date after you make a COBRA continuation election that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;

- the date after you make a COBRA continuation election that you first become entitled to Medicare; or

- the date the employer no longer provides group health coverage to any of its employees

Q-14. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) which are based on taxable compensation.

Please note: FMLA applies to employers with 50 or more employees.

Q-15. What is the Family and Medical Leave Act?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage (including the Health Care Reimbursement Account) on the same terms and conditions as though

you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

(c) In the event of unpaid leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave on a pre-tax salary redirection basis out of your pre-leave Compensation by making a special election to that effect before the date such compensation would normally be made available to you (provided, however, that pre-payments of pre-tax dollars may not be utilized to fund coverage during the next Plan Year), or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). If the Employer requires all Participants to continue coverage during the leave, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or otherwise required by the FMLA. Your Coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. Notwithstanding the preceding sentence, with regard to Health Care Reimbursement Accounts, if your coverage ceased during your FMLA leave, you will be entitled to elect whether to be reinstated in the Health Care Reimbursement Account at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at Health Care Reimbursement Account coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

(e) The Employer may, on a uniform and consistent basis, continue your group health

for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Q-7 of this Part I will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

PART II

Health Care Reimbursement Account

If provided for in Q-2 of Part I or in the attached Plan Information Summary, you will have the opportunity to elect to receive income tax-free reimbursement ("Health Care Reimbursements") for some or all of your unreimbursed health care expenses ("Eligible Medical Expenses") under the Health Care Reimbursement Account ("HCRA"). Under the HCRA, you purchase a specific level of Health Care Reimbursement benefits, paying for coverage through the Salary Reduction Agreement with the Employer, in lieu of a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save social security and income taxes on the amount of the premiums you pay. **If Health Care Reimbursements provided through the HCRA are not provided for in Q-2 of Part I above or in the attached Plan Information Summary, this Part II does not apply.**

QUESTIONS & ANSWERS

Q-1. Who can participate in the HCRA?

Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week is eligible to participate in the HCRA on the first of the month following date of hire.

If the Plan Administrator receives a medical child support order relating to the HCRA, the HCRA will provide the health benefit coverage specified in the order to the person or person ("alternate recipients") named in the order (to the extent such coverage is provided under the HCRA) if the medical child support order is a "Qualified Medical Child Support Order". "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "medical child support order" is a legal judgment, decree or order relating to medical child support. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

Q-2. How do I become a Participant?

By electing Health Care Reimbursement benefits during the Initial or Annual Enrollment Periods. (The Initial and Annual Enrollment Periods are described in Q-5 of Part I).

Q-3. What is my "Health Care Reimbursement Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing health care account ("Health Care Account" or "Health FSA") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the contributions you have made for such benefits during the Plan Year.

Q-4. What is the maximum annual Health Care Reimbursement that I may elect under the HCRA, and how much will they cost?

You may choose any annual Health Care Reimbursement amount you desire subject to the maximum Health Care Reimbursement amount of $2,400 and a minimum reimbursement amount of $180 per Plan Year. For the Initial Plan Year, (October 1, 2003 through September 30, 2004) only, you may choose any amount of Initial Plan Year Health Care Reimbursement you desire subject to the maximum annual Health Care Reimbursement amount of $2,400 and a minimum reimbursement amount of $180. You will be required to pay the annual premium equal to the coverage level you have chosen reduced by any nonelective contribution or Benefit Credits (if any) allocated to your Health Care Account.

Q-5. How do I pay for Health Care Reimbursement benefits?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with your salary reduction. You also specify the amount of Benefit Credits (if available as provided for in the Plan Information Summary and/or the enrollment material) that you wish to allocate to your Health Care Account. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium, reduced by any Benefit Credits and/or Nonelective Contributions (if any) allocated to your Health Care Account, deducted from each paycheck. If you chose to allocate all or a portion of your Benefit Credits to your Health Care Account, we will credit your Health Care Account each pay period with an equal portion of the annual Benefit Credits you elected to allocate to your Health Care Account. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket Eligible Medical Expenses incurred at any time during the Plan Year, so long as you continue to pay the premiums.

For example, suppose you have elected to be reimbursed for up to $1,000 per year for Eligible Medical Expenses, and you have chosen no other benefits under the Cafeteria Plan. Your Account would be credited (and funded) with a total of $1,000 during the Plan Year. If you are paid bi-weekly, your Account would reflect that you have paid $38.46 per pay period in premiums for the benefit you have elected.

Q-6. What amounts will be available for Health Care Expense Reimbursement at any particular time during the Plan Year?

Provided that you have continued to pay the periodic premiums due for this benefit, the full, annual amount of Health Care Reimbursement you have elected will be available at any time

during the Plan Year, reduced however by the amount of previous Health Care Reimbursements received during the Year.

Q-7. How do I receive reimbursement under the HCRA?

If you elect to participate in the HCRA, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an Eligible Medical Expense, you submit a written or electronic claim to the Plan's Administrator. The written claim form will be supplied to you. You must include written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with the claim form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) which you are obligated to pay.

You will be reimbursed for your Eligible Medical Expenses during the next processing period after which you submitted the claim. Remember, though, you can't be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You will have ninety (90) days after the end of the Plan Year in which to submit a claim for reimbursement for Eligible Medical Expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is <u>not</u> necessary that you have actually paid an amount due for an Eligible Medical Expense -- only that you have <u>incurred</u> the expense (i.e., the services to which the expense relates have been provided), and that it is not being paid for or reimbursed from any other source.

Q-8. What is an "Eligible Medical Expense?"

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible Dependents that satisfies the following conditions: (i) the expense is for “medical care” as defined by Code Section 213(d) and (ii) the expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines “medical care” as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs. Not every health-related expense you or your eligible Dependents incur will constitute an expense for “medical care”. For example, as defined by the Code, an expense is not for “medical care” if it is merely for the beneficial health of you and/or your eligible Dependents (i.e. vitamins or nutritional supplements that are not taken to treat a specific medical condition). Expenses for

cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any HCRA (per IRS regulations): (i) health insurance premiums and (ii) expenses incurred for qualified long term care services.

The Claims and Plan Administrator have the authority to request additional substantiation if the Claims or Plan Administrator deems it necessary to properly substantiate that the expense was for "medical care".

Q-9. When must the expenses be incurred for which I may be reimbursed?

Eligible Medical Expenses must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan (or if later, the HCRA) became effective, before your Salary Reduction Agreement becomes effective, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage, after a separation from service.

Q-10. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. Any amount allocated to a Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs, or applied in a manner that is consistent with applicable rules and regulations.

Q-11. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

PART III

Dependent Care Reimbursement Account

If provided for in the attached Plan Information Summary, you may elect to receive income tax-free reimbursement ("Dependent Care Reimbursements") for some or all of your work-related dependent care expenses ("Eligible Employment Related Expenses") under the Dependent Care Reimbursement Account ("DCRA"). Under these provisions, you provide a source of pre-tax funds to reimburse yourself for your Eligible Employment Related Expenses by entering into a Salary Reduction Agreement with your Employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is nontaxable; you save social security and income taxes on the amount of your salary conversion. **If Dependent Care Reimbursements provided through the DCRA are not provided for in the Q-2 of Part I above or the Plan Information Summary, this Part III does not apply**.

Questions & Answers

Q-1. Who can participate in the Plan?

Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week is eligible to participate in the DCRA on the first of the month following date of hire.

Q-2. How do I become a Participant?

By electing Dependent Care Reimbursement benefits during the Initial or Annual Enrollment Periods. The Initial and Annual Enrollment Periods are described above in Q-5 of Part I.

Q-3. What is my "Dependent Care Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing dependent care account ("Dependent Care Account") will be set up in your name to keep a record of the Dependent Care Reimbursements you are entitled to.

Q-4. What is the maximum annual Dependent Care Reimbursement that I may elect under the DCRA?

This annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently the lesser of $5,000 ($180 minimum per Plan Year), or the amount set forth in the Plan Information Summary per Plan Year if you -

- are married and file a joint return;

- are married but your spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or

- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive cannot exceed the lesser of the earned income (as defined in Code Section 32) of you or your spouse. For purposes of (d) above, your spouse will be deemed to have Earned Income of $*250* ($*500* if you have two or more Qualifying Individuals described in paragraph 2 above), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Q-5. How is my Account funded?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care Reimbursements for which you wish to pay with your salary reduction. You also specify the amount of Benefit Credits that you wish to allocate to your account (if available as provided for in the attached Plan Information Summary and/or the enrollment material). Thereafter, your Dependent Care Account will be credited with that portion of your gross income you have elected to forego through salary reduction. If you allocate all or a portion of your Benefit Credits to your Dependent Care Account, we will credit your Dependent Care Account each pay period with an equal portion of the annual Benefit Credits you elected to allocate to your Dependent Care Account. These portions will be credited as of each pay period.

For example, suppose you have elected to be reimbursed for $2,600 per year for Eligible Employment Related Expenses, and you have chosen no other benefit under the Plan. Your Dependent Care Account would be credited with a total of $2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of $100 credited to your Account each payday to pay reimbursements under this Plan. The amount that is available to your Dependent Care Account at any particular time will be whatever has been credited to such Account less any reimbursements already paid.

Q-6. What is an "Eligible Employment Related Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Employment Related Expenses") incurred on behalf of any individual in your family who is under age 13, who resides with you and for whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself; or your Spouse, if the Spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet all of the following conditions for them to be Eligible Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expenses is a "Qualifying Individual." A Qualifying Individual is:

   (A) a Dependent age 12 or under who resides with you and for whom you are entitled to a personal tax exemption as a dependent (as defined by the U.S. Tax Code), unless you are divorced and the child lives with you but you have permitted the non-custodial parent to take the exemption, or

   (B) a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself

3. The expenses are incurred for the care of a Qualifying Individual (as described above), or for related household services, and are incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

7. This Dependent Care Reimbursement (when aggregated with all other Dependent Care Reimbursements benefits during the same year) may not exceed the least of the following limits:

   (a) $5,000 or such lesser amount set forth in the Plan Information Summary.

   (b) $2,500, if you are married but you and your Spouse file separate tax returns.

   (c) Your taxable compensation (after your salary Reduction under the Cafeteria Plan).

   (d) If you are married, your Spouse's actual or deemed Earned Income.

   For purposes of (d) above, your Spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time Student.

8. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-7. How do I receive reimbursement under the DCRA?

If you have elected to participate in the DCRA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. The written claim form will be supplied to you. If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

In addition, you will have ninety (90) days after the end of the Plan Year in which to submit a claim for reimbursement of Eligible Employment Related Expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

Q-8. What if the Eligible Employment Related Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs.

Q-9. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not normally be taxed on your Dependent Care Reimbursement, provided that your family's aggregate Dependent Care Reimbursement (under this DCRA or another employer's DCRA) does not exceed the limits set out in Q-4 of this Part III for the Plan Year. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-10. If I participate in the DCRA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this DCRA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-11. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1050 for one Qualifying Individual or $2100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income that exceeds $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1152, because the entire expense would have been taken into account, not just the first $3,000.

Q-12. When would I be better off to include the Dependent Care Reimbursements in my income and claim the credit, rather than to treat the Dependent Care Reimbursements as tax-free?

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by including the Dependent Care Reimbursements in income, and claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat Dependent Care Reimbursements as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-13. What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

PART IV

Individual Premium Reimbursement Account

If provided for in Q-2 of Part I above or the attached Plan Information Summary, you may elect to receive income tax-free reimbursement for some or all of your Eligible Individual Premium Expenses. Under these provisions, you provide a source of pre-tax funds to reimburse yourself for expenses you incur for certain individual accident or health insurance coverage ("Eligible Individual Premium Expenses") by entering into a Salary Reduction Agreement with your Employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the reimbursement you receive is nontaxable; you save social security and income taxes on the amount of your salary conversion. **If Individual Premium Reimbursement under the Individual Premium Reimbursement Account is not provided for in Q-2 of Part I above or in the Plan Information Summary, this Part IV does not apply.**

Q-1. Who is eligible for Individual Premium Reimbursement?

Each employee who is eligible to participate in the Flexible Benefits Plan is eligible for Individual Premium Reimbursement.

Q-2. How Do I Become a Participant?

During the Initial or Annual Enrollment Periods, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased outside of any Employer plan for yourself (or yourself and your dependents who are otherwise eligible for coverage under the Employer's group health plan) and (b) indicate on the enrollment form the amount that you will expect to pay during the Plan Year for such individual accident or health insurance policy. The Plan Administrator will notify you if the insurance policy is determined to be a "qualified benefit" under the Plan. If you do not elect Individual Premium Reimbursement during the Initial and Annual Enrollment Periods, you will not be able to enroll until the next Annual Enrollment Period.

Q-3. What is an Eligible Individual Premium Expense for which I can request payment?

To be an Eligible Individual Premium Expense, the individual insurance that you purchase outside of any Employer Plan must meet the following conditions: (a) the individual insurance policy must be pre-determined by the Plan Administrator to be a "Qualified Benefit" as defined by the Code, prior to the beginning of the Plan Year or, if you are a new hire, prior to the effective date of your coverage under the Plan; (b) the insurance policy must be a policy that provides accident or health insurance (for example, health, dental, vision and disability) as defined by the Code; (c) the contract must be an individually purchased contract and not an employer sponsored insurance plan; (d) you must be the policyholder of the insurance policy (if

applicable, your spouse or dependents who would otherwise be eligible for coverage under the Employer's group health plan may also be covered under the individual accident or health insurance policy); and (e) the premium for the insurance coverage must be billed directly to you.

Q-4. How do I pay for Eligible Individual Premium Expenses?

When you elect to participate in the Individual Premium Reimbursement Account on the Salary Reduction Agreement, a non-interest bearing premium reimbursement account ("Individual Premium Account") will be established for you. An amount equal to the annual premiums you expect to pay during the Plan Year divided by the number of pay periods in the Plan Year will be deducted from your pay each pay period and credited to your Individual Premium Account for reimbursement of Eligible Individual Premium Expenses.

For example, suppose the annual premium for an individual health insurance policy that you have purchased equals $2,600. Also, assume that you have chosen no other benefit under the Employer's Flexible Benefits Plan. $2,600 will be deducted from your pay during the Plan year and credited to your Account for reimbursement of the premium that you pay. Thus, if you are paid bi-weekly, you would have a total of $100 credited to your Account each payday to pay reimbursements under this Plan.

Q-5. How Do I Receive Reimbursement Under the Plan?

If you have elected to participate in this portion of the Plan, you will have to take certain steps to be reimbursed for your Eligible Individual Premium Expenses. When you pay an Eligible Individual Premium Expense, you submit a written or electronic claim to the Plan's Administrator. Written claim forms will be supplied to you. In addition, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Eligible Individual Premium Expenses for which you are requesting reimbursement. A reimbursement check payable to you will be paid at the next processing cycle. You will only receive reimbursement up to the amount that has been deducted from your pay and credited to your Individual Premium Account reduced by any prior Individual Premium Reimbursements.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. In addition, you will have ninety (90) days after the end of the Plan Year in which to submit a claim for reimbursement for Eligible Individual Premium Expenses that you paid during the previous Plan Year. You will be notified in writing if any claim for benefits is denied. Any amount allocated to an Individual Premium Reimbursement Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year within ninety (90) days following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs.

You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective or for any expense incurred after the close of the Plan Year.

PART V

Electing Less Than The Maximum Annual Benefit

Any portion of your Compensation that you do not choose to apply toward the purchase of the benefits described above will be paid to you as regular, taxable Compensation.

PART VI

PLAN INFORMATION SUMMARY
McGregor Independent School District
Flexible Benefits Plan

This Part VI provides general information about the Plan.

I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	**McGregor Independent School District** **525 Bluebonnet Parkway** **McGregor, TX 76657** **1-254-840-2828**
2. Name, address, and telephone number of the Plan Administrator:	**McGregor Independent School District** **525 Bluebonnet Parkway** **McGregor, TX 76657** **1-254-840-2828**
3. Employer's federal tax identification number:	**74-6001669**
4. Plan Number:	**#501**
5. Original Effective Date of the Plan:	**November 1, 1988**
6. Effective Date of Amendment/Restatement:	**October 1, 2003**
7. The initial Plan Year:	**October 1, 2003 through September 30, 2004**
8. All subsequent Plan Years:	**October 1 through September 30**
9. Affiliated Employers participating in the Plan:	**None Affiliated**
10. Plan Service Provider/Third Party Administrator:	**FlexBen Corporation** **10404 North Baehr Road** **Mequon, WI 53092**

II. ELIGIBILITY

(a) Flexible Benefits Plan. Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week and who is eligible for coverage or participation under any of the Benefit Package Options shall be eligible to participate in this Plan upon the Entry Date set forth below.

(b) **PREMIUM EXPENSE ACCOUNT.** Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week shall be eligible to participate in the Premium Expense Account upon the Premium Expense Account Entry Date set forth below.

(c) **HCRA.** Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week shall be eligible to participate in the HCRA upon the HCRA Entry Date set forth below.

(d) **DCRA.** Each Employee who is regularly scheduled to work a minimum of twenty (20) hours per week shall be eligible to participate in the DCRA upon the DCRA Entry Date set forth below.

III. ENTRY DATE

(a) Flexible Benefits Plan. An eligible Employee may become a Participant in this Plan on the first of the month following date of hire**.**

(b) **PREMIUM EXPENSE ACCOUNT.** An eligible Employee may become a Participant in the Premium Expense Account (if such Plan is elected below) on the first of the month following date of hire.

(c) **HCRA.** An eligible Employee may become a Participant in the HCRA (if such Plan is elected below) on the first of the month following date of hire.

(d) **DCRA.** An eligible Employee may become a Participant in the DCRA (if such Plan is elected below) on the first of the month following date of hire.

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in

Summary Plan Description and/or the enrollment materials. Eligibility for coverage under any given Benefit Package Option shall be determined not by this Plan but by the terms of that Benefit Package Option, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contributions under this Plan shall commence whether Employee becomes covered under the applicable Benefit Package Option.

IV. BENEFIT CREDITS

The Employer may, as indicated below, provide Benefit Credits (as defined in the Plan) to each Participant to apply, at the Participant's discretion, towards the cost of one or more of the Benefit Package Options available under the Plan. Benefit Credits, if selected below, are in addition to any Nonelective Contributions (as defined by the Plan) made by the Employer on behalf of each Participant.

Benefit Credits will not be provided under this Plan.

V. BENEFITS PROVIDED UNDER THE PLAN

The Employer elects to offer to eligible Employees the following Benefit Package Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Package Options. These component Benefit Package Option(s) are specifically incorporated herein by reference. The maximum Pre-Tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Package Options selected minus any Benefit Credits allocable thereto and any Nonelective Contribution made by the Employer. It is intended that such Pre-Tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

1. Premium Expense Account

2. Health Care Reimbursement Account

3. Dependent Care Reimbursement Account

4. If offered under the Plan, Health Care Reimbursement, described in Part II of the Summary Plan Description attached hereto, shall not exceed the lesser of the amount elected under the Plan or $2,400, per Plan Year, pursuant to the terms of the HCRA. The minimum reimbursement amount that may be elected under the Plan is $180. For the initial Plan Year, October 1, 2003 through September 30, 2004, the maximum reimbursement amount shall be the amount elected under the Plan or $2,400, whichever is less.

5. If offered under the Plan, Dependent Care Reimbursement, described in Part III of the Summary Plan Description attached hereto, shall not exceed the lesser of the amount elected under Plan or the lesser of $5,000 ($180 minimum) per Plan Year (or $2,500 for married filing separate returns), pursuant to the terms of the DCRA.

6. Opt-out Option. Additional taxable compensation for certain Employees who opt-out of certain Benefit Package Options (as described in the enrollment materials) is not offered under the Plan.

7. Cash Option. Additional taxable compensation equal to all or a portion of the Benefit Credits that exceed the cost of the Benefit Package Option(s) selected by the Participant is not offered under the Plan. The available Cash Option amount will be set forth in the enrollment materials.