SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	**BRAZORIA COUNTY**
Address:	**111 E. LOCUST STREET** **ANGELTON, TEXAS 77515**
Employer Identification Number:	**74-6000044**
Nature of Business:	**GOVERNMENT ENTITY**
Name of Plan:	**BRAZORIA COUNTY** Flexible Benefit Plan
Plan Number:	**501**

B. EFFECTIVE DATE

Original effective date of the Plan:	**FEBRUARY 1, 1987**
If Amendment to existing plan, effective date of amendment:	**JUNE 1, 2005**

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	**First day of month following employment.**
Minimum Hours:	All employees with **30** hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	**Minimum age of 18 years.**

D. PLAN YEAR

The current plan year will begin on **January 1, 2005**, and end on **December 31, 2005.** Each subsequent plan year will begin on **January 1** and end on **December 31.**

CC → 1st Fin. (Talbot) 4-26-05

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts may be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$12,000

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

   MEDICAL – SELF-FUNDED (BLUE CROSS/BLUE SHIELD)

   Eligibility Requirements for Participation, if different than Item C.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

   COLONIAL LIFE & ACCIDENT

   Eligibility Requirements for Participation, if different than Item C.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

   AMERICAN FIDELITY ASSURANCE COMPANY

   Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

   DENTAL – NATIONAL PACIFIC
   VISION – SPECTERA

   Eligibility Requirements for Participation, if different than Item C.

5. **Group Life Insurance** which will be comprised of Group-term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

N/A

Eligibility Requirements for Participation, if different than Item C.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

Minimum Contribution - $ **200-** per Plan Year

Maximum Contribution - $ **5,000** per Plan Year

Recordkeeper: **First Financial Administrators, Inc.**

Eligibility Requirements for Participation, if different than Item C.

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:

Minimum Coverage - $ **200** per Plan Year or a Prorated Amount for a Short Plan Year

Maximum Coverage - **$ 9,600** per Plan Year or a Prorated Amount for a Short Plan Year

Recordkeeper: **First Financial Administrators, Inc.**

Eligibility Requirements for Participation, if different than Item C.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Texas. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted this 25 **day of** April, **20** 06.

BRAZORIA COUNTY
(Name of Employer)

Witness: Sherilyn Plentl
Title: Court Coordinator

By: John Willy
Title: County Judge

THIS DOCUMENT IS NOT COMPLETE WITHOUT PAGES 7 THROUGH 27

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01	**Administrator**	The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).
2.02	**Beneficiary**	Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.
2.03	**Code**	Internal Revenue Code of 1986, as amended.
2.04	**Dependent**	A Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152.
2.05	**Effective Date**	The effective date of this Plan as shown in Item B of the Adoption Agreement.
2.06	**Elective Contribution**	The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.
2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.

2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 10.01 and 10.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.19	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.
2.20	**Non-Elective Contribution**	A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
2.21	**Participant**	An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.
2.22	**Plan**	The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.

2.23 **Plan Year** The Plan Year as specified in Item D of the Adoption Agreement.

2.24 **Policy** An insurance policy issued as a part of this Plan.

2.25 **Preventative Care** Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.

2.26 **Recordkeeper** The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.

2.27 **Related Employer** Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the entry date specified or the effective date of the Plan, whichever is later. The Employer must notify the Employee of his eligibility to participate in the Plan so that the Employee shall complete the necessary enrollment forms on or before the entry date.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder. Notwithstanding anything to the contrary herein, to the extent required by the Health Insurance Portability and Accountability Act of 1996, the Plan shall permit a special

enrollment period for employees who have previously declined coverage under the Plan; a new dependent may also justify a special enrollment period.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee; or
c. The date of termination of the Plan; or
d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 SEPARATION FROM SERVICE: The Employer shall, on a reasonable and consistent basis, permit an Employee who separates from the employment service of the Employer during a Plan Year to revoke his existing elections and terminate the receipt of benefits for the remaining portion of the Plan Year.

3.05 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes 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 the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary

reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special HIPAA Enrollment Rights. If a Participant, spouse or Dependent enrolls in the health insurance plan pursuant to special enrollment rights under HIPAA, the Participant may make a corresponding change in election under this Plan. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer 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 cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the

Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan, shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable

provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum overage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

8.04 ELIGIBLE MEDICAL EXPENSES: The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Section 125 and its regulations, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, from any other source. In addition, medical care expense incurred by a Participant or the Participant's Dependent(s) prior to the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall not constitute an Eligible Medical Expense. Provided, however, if the Employer has elected in Section F.8 of the Adoption Agreement to allow Health Savings Accounts under the Plan, then for participants who are eligible for and elect to participate in Health Savings Accounts (i) Eligible Medical Expenses shall be limited as set forth in Section F.8 of the Adoption Agreement, and (ii) the Health Savings Account will reimburse Eligible Medical Expenses only after the Participant has received the maximum amount reimbursable to him under the Medical Expense Reimbursement Plan for the Plan Year, unless the Participant is covered by a High Deductible FSA, in which case the Health Savings Account will pay Eligible Medical Expenses prior to the Medical Expense Reimbursement Plan until the amount of Eligible Medical Expenses equals the High Deductible FSA limit, and thereafter, the Medical Expense Reimbursement Plan will pay Eligible Medical Expenses prior to the Health Savings Account.

8.05 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.05 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending 70 days after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year. Prior to the start of a Grace Period, a Participant shall be entitled to elect to restrict the Eligible Medical Expenses incurred during the Grace Period that may be reimbursed from the unused contributions made in the prior Plan Year to only vision and dental expenses.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

e. Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

a. "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

b. "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);

(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and

(iii) satisfies all applicable laws and regulations of a state or unit of local government.

c. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;

(ii) paid or payable to a Dependent Care Service Provider; and

(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or

(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's

approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized

representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Group Medical Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section shall be effective on April 14, 2004 or on such other date required by 45 CFR Section 164.534. The Plan may disclose PHI to employees of the Employer with employee benefits responsibility or to employees with oversight

responsibility for third party administrator claims administration. Access to and use by such individuals must be restricted to plan administration functions that the plan sponsor performs for the Plan. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Plan may disclose PHI to such individuals only if the Employer certifies that the Plan documents have been amended to incorporate the following specific provisions, and the Employer agrees to comply with them. The Employer will:

- not use or further disclose PHI other than as permitted by the plan documents or as required by law;
- ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer;
- not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- make available to Plan participants, consider their amendments and, upon their request, provide them with an accounting of PHI disclosures;
- make its internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and
- will, 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 information when no longer needed for the purposes for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 164.501, which is individually identifiable health information that is maintained or transmitted by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

13.01 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.02 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.03 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.04 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.05 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.