COUNTY OF SAN DIEGO

CAFETERIA PLAN

PLAN DOCUMENT

As Adopted Effective: October 1, 1990
Amended & Restated: March 1, 2006; January 1, 2008; January 1, 2010; June 1, 2010; January 1, 2011; January 1, 2013; January 1, 2014; January 1, 2016; January 1, 2018 and January 1, 2019

Intentionally Left Blank

Table of Contents

PREAMBLE

Effective **October 1, 1990 (and as Amended and Restated on March 1, 2006; January 1, 2008; January 1, 2010; June 1, 2010; January 1, 2011; January 1, 2013; January 1, 2014; January 1, 2016, January 1, 2018; January 1, 2019)**, **COUNTY OF SAN DIEGO** established a Cafeteria Plan (the "Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the Benefit Plan Options available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code § 125.

The Health Care Spending Account ("HCSA"), is intended to qualify as a Code § 105 self-insured medical expense reimbursement plan, and that the benefits provided under the Health Care Spending Account be eligible for exclusion from the Participant's income for federal income tax purposes under Code § 105(b). The Limited Purpose Health Care Spending Account ("LPHCSA"), is intended to qualify as a Code § 105 self-insured dental and vision expense reimbursement plan, and that the benefits provided under the Limited Purpose Health Care Spending Account be eligible for exclusion from the Participant's income for federal income tax purposes under Code § 105(b).The Dependent Care Spending Account ("DCSA"), is intended to qualify as a Code § 129 dependent care assistance plan and that the benefits provided under the Dependent Care Spending Account be eligible for exclusion from the Participant's income for federal income tax purposes under Code § 129. Although printed within this document, the HCSA, LPHCSA and DCSA Plans are separate written plans for purposes of administration and nondiscrimination requirements imposed by Sections 105 and 129 of the Code.

COUNTY OF SAN DIEGO
CAFETERIA PLAN

ARTICLE I
DEFINITIONS

1.01 **"Affiliated Employer"** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

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

1.03 **"Benefit Plan Option(s)"** means those Qualified Benefits available to a Participant under this Plan as set forth in the Summary Plan Description, as amended and/or restated from time to time.

1.04 **"Board of Directors"** means the Board of Directors or other governing body of the Employer (the "Board"). The Board of Directors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.05 **"Change in Status"** means any of the events described in the Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the Summary Plan Description for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

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

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

1.08 **"Dependent"** means:

- Legal Spouse;
- Children under age 26 for coverage on Dental and Vision plans;
- Children under age 26 for coverage on Medical plans;
- Children who will not reach age 27 during the calendar year for expenses to be reimbursed under the Health Care Spending Account plan or Limited Purpose Health Care Spending Account as defined generally in Code Section 152 and 105(b);
- Unmarried children of any age who are physically or mentally handicapped;
- Registered Domestic Partner as defined by California law who is a tax dependent of the Participant as defined generally in Code Section 152;
- Domestic Partner and Domestic Partner's eligible dependents so long as they meet the relationship criteria established by the County of San Diego and are tax dependents of the Participant as defined generally in Code Section 152 and 105(b).

For Dependent Care FSA (if offered under the Plan) purposes, a Dependent also means an individual described in Code Section 21(e)(5) (i.e., dependent of the parent with custody for the greatest portion of the year).

Note: Children of Participants who are employed by Employer and eligible for their own benefits are considered Participants and may not be carried as Dependents.

1.09 **"Dependent Care Spending Account"** shall have the meaning assigned to it by Section 6.03 of the Plan.

1.10 **"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 includible in gross income for the taxable year. Earned income does not include any amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.11 **"Effective Date"** of this Plan means the original effective date of the Cafeteria plan, or the amended and restated effective date, set forth in the SPD.

1.12 **"Eligible Dental or Vision Expenses"** means those expenses that are eligible for reimbursement under the Limited Purpose Health Care Spending Account as set forth in the SPD, incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the Limited Purpose Health Care Spending Account 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 § 213(d) but limited to dental and vision care. For purposes of this Plan, the following expenses are not considered Eligible Dental or Vision Expenses even if they otherwise constitute medical care under Code § 213(d):

i) Expenses for qualified long-term care services (as defined in Code § 7702B);
ii) Expenses for health, dental and vision insurance premiums;
iii) Expenses for cosmetic surgery or other similar procedures, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
iv) The salary expense of a nurse to care for a healthy newborn at home;
v) Funeral and burial expenses;
vi) Expenses for Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
vii) Expenses for custodial care;
viii) Costs for sending a child to a special school for Benefits that the child may receive from the course of study and disciplinary methods;
ix) Expenses for social activities, such as dance lessons (even if recommended by a physician for general health improvement);
x) Expenses for cosmetics, toiletries, toothpaste, etc;
xi) Expenses for uniforms or special clothing, such as maternity clothing;
xii) Only reasonable quantities of over the counter drugs obtained with a valid prescription and supplies may be reimbursed in a single calendar month. Stockpiling of over the counter drugs and supplies is not allowed;

xiii) Expenses for over the counter drugs without providing documentation indicating a valid prescription; and

xiv) Expenses for marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

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 except in the case of certain advance payments for orthodontia. A cafeteria plan is permitted, but not required, to reimburse employees for orthodontic services before the services are provided but only to the extent the participant has paid for such services in order to receive the services. In this instance, orthodontic services are deemed to be "incurred" when the participant makes the advance payment.

1.13 "Eligible Employment Related Expenses" means those expenses that would be considered to be Employment-Related Expenses under Code § 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code § 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 taxable year in which the expenses were incurred.

1.14 "Eligible Medical Expenses" means those expenses that are eligible for reimbursement under the Health Care Spending Account as set forth in the SPD, incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the Health Care Spending Account 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 § 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 § 213(d):

i) Expenses for qualified long-term care services (as defined in Code § 7702B);

ii) Expenses for health insurance premiums;

iii) Expenses for cosmetic surgery or other similar procedures, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;

iv) The salary expense of a nurse to care for a healthy newborn at home;

v) Funeral and burial expenses;

vi) Expenses for Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);

vii) Expenses for custodial care;

viii) Costs for sending a child to a special school for Benefits that the child may receive from the course of study and disciplinary methods;

ix) Expenses for social activities, such as dance lessons (even if recommended by a physician for general health improvement);

x) Expenses for cosmetics, toiletries, toothpaste, etc.;

xi) Expenses for uniforms or special clothing, such as maternity clothing;

xii) Only reasonable quantities of over the counter drugs obtained with a valid prescription and supplies may be reimbursed in a single calendar month. Stockpiling of over the counter drugs and supplies is not allowed;

xiii) Expenses for over the counter drugs without providing documentation indicating a valid prescription; and

xiv) Expenses for marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

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 except in the case of certain advance payments for orthodontia. A cafeteria plan is permitted, but not required, to reimburse employees for orthodontic services before the services are provided but only to the extent the participant has paid for such services in order to receive the services. In this instance, orthodontic services are deemed to be "incurred" when the participant makes the advance payment.

1.15 "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 of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) 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.

1.16 "Employer" means **COUNTY OF SAN DIEGO** and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Notwithstanding the previous sentence when the Plan provides that the Employer has a certain power (e.g., the appointment of a third-party administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only **COUNTY OF SAN DIEGO.** 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 the Summary Plan Description.

1.17 "False or Fraudulent Claims" means claims that are determined to be falsified or fraudulent in nature. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for benefits.

1.18 "Flexible Spending Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Spending Account Payments (the "HCSA") (as defined in Section 1.19 herein) and Dependent Care Spending Account Payments (the "DCSA")(as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the Summary Plan Description. 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).

1.19 **"Health Care Spending Account"** shall have the meaning assigned to it by Section 6.01 of the Plan.

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

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

1.22 **"Limited Scope Health Care Spending Account"** shall have the meaning assigned to it by Section 6.02 of the Plan.

1.23 **"Non-elective Contribution(s)"** means any amount which 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 Plan Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be 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. To the extent set forth in the Summary Plan Description or enrollment material, the Employer may make Non-elective Contributions available to Participants and allow Participants to allocate the Non-elective Contributions among the various Benefit Plan Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment material. In no event will any Non-elective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment material.

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

1.25 **"Plan"** means this Cafeteria Plan as set for herein.

1.26 **"Plan Administrator"** means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion 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 Year"** shall be the period of coverage set forth in the Summary Plan Description.

1.28 **"Pretax Contribution(s)"** means any amount withheld from the Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plan

Options available under the plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan Option afforded hereunder, and for purposes of Code § 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.29 **"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 § 79). A "Qualified Benefit also includes Pre-Tax Contributions to a health savings account subject to the annual IRS limits. Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."

1.29 **"Qualifying Individual"** means an individual defined as a "Qualifying Individual" in the Summary Plan Description.

1.30 **"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.

1.31 **"Salary Reduction Agreement"** means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Plan Options with Pretax or After-tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. 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 in accordance with all applicable federal and/or state laws.

1.32 **"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 Spending Account Plan provisions, shall not 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.

1.33 **"Summary Plan Description" or SPD"** means the Cafeteria Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and associated to this Plan Document, and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of the Eligibility Date set forth in the SPD. Eligibility to participate in this Plan means only that the Eligible Employee is entitled to contribute his share of the cost of applicable Benefit Plan Options for which he is eligible with Pretax Contributions. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Plan Option(s) and the terms of eligibility and participation for the Benefit Plan Option(s) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Plan Options.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD. Participation may also be terminated if the Plan Administrator determines that the Participant has filed a false or fraudulent claim for benefits.

2.03 Eligibility to Participate in Flexible Spending Accounts. Each employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Flexible Spending Accounts, if adopted by the Employer, on the applicable Eligibility Date set forth in the SPD.

2.04 Qualifying Leave Under Family Leave Act. 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 Participant will be entitled to continue the Participant's Benefits Package Options that provide health coverage (including Health Care Spending Account and Limited Scope Health Care Spending Account benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code § 125 and in accordance with the FMLA.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plan Options chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility, under this Plan or the Benefit Plan Options chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but 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. If such policy does not require coverage to continue during the leave but permits a Participant to choose whether or not to participate while on leave, then the Participant may: a) choose to continue to receive reimbursements while on leave, or b) choose not to receive reimbursements while on leave. If the Participant chooses to continue to receive reimbursements while on leave, the

Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave. If the Participant chooses not to receive reimbursements while on leave, the Participant will, upon returning from leave, have the option to decrease the annual election to reflect the loss of coverage during the leave of absence.

ARTICLE III
ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pretax Contributions or After-tax Contributions (to the extent set forth in the enrollment material) to fund any Benefit Plan Option available under the Plan, provided that only Qualified Benefits may be funded with Pretax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plan Options offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Non-elective Contributions among the various Benefit Plan Options in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) Currently Eligible Employees. An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan 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 Sections 3.04 and 3.05, for the Plan Year beginning on the Effective Date.

(b) New Employees and Employees Who Have Not Yet Satisfied The 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 (or its designated third-party administrator as set forth on the Salary Reduction Agreement) during the initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plan Options will be effective in accordance with the governing provisions of such Benefit Plan Options (but in no event prior to the election).

(c) Failure to Elect. An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement 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." The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An Election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 Change of Elections.

A Participant shall not make any changes to the Pretax Contribution amount or, where applicable, to the Participant's elected allocation of Non-elective Contributions except for under the circumstances set forth in the SPD and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility, and changes pursuant to the Family and Medical Leave Act.

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, 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. The circumstances under which a Participant may change his election under this Plan is set forth in the SPD.

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 Pretax Contributions may be made by such Participant during the remainder of the Plan Year except as set forth in the SPD.

ARTICLE IV
PREMIUM PAYMENTS AND CREDITS AND DEBITS TO ACCOUNTS

4.01 **Source of Benefit Funding.** The cost of coverage under the component Benefit Plan Options shall be funded by Participant's Pretax and/or After-tax Contributions and/or any Non-elective Contributions provided by the Employer. The required contributions for each Benefit Plan Options offered under the plan shall be made known to employees in enrollment materials. Pretax or After-tax Contributions (as elected by the Employee on the Salary Reduction Agreement and permitted by the Employer) shall equal the contributions required from the Participant less an available Non-elective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plan Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pretax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pretax Contributions, plus any Non-elective Contribution made available by the Employer, shall not exceed the aggregate cost of the Benefit Plan Options elected.

4.02 **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 Pretax 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 Individuals or Key Employee's election without the consent of such Employee.

ARTICLE V

BENEFITS

5.01 Qualified Benefits. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of the aggregate premium and/or contribution for all Benefit Plan Option(s) set forth in the SPD.

5.02 Excess Benefit Credits. To the extent that a Participant does not elect to have the maximum amount of his Benefit Credits contributed as a Pretax Contribution or After-tax Contribution hereunder, such amount shall be automatically placed into the Participant's Health Care Spending Account or Limited Purpose Health Care Spending Account, unless the Participant elects to have it deposited into a Dependent Day Care Account. Under no circumstances will the Participant receive a cash benefit.

ARTICLE VI
REIMBURSEMENTS

6.01 Health Care Spending Account Reimbursement. Each Participant's Health Care Spending Account will be credited with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for health care reimbursements disbursed to the Participant in accordance with this Article VI. 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 to the participant for Expenses incurred during the plan year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Spending 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 be related to the amount that a Participant has had credited to his Health Care Spending Account. 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. The Participant must be actively contributing to the account in order to be eligible to receive reimbursement. A Participant who is on an unpaid leave of absence, or terminates employment is no longer actively contributing, and therefore, is not eligible to request reimbursements. Any amount credited to the Health Care Spending Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the run-out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor or Internal Revenue Service regulations. The maximum annual reimbursement under the Health Care Spending Account shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

6.02 Limited Purpose Health Care Spending Account Reimbursement. Each Participant's Limited Purpose Health Care Spending Account will be credited with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for dental and/or vision reimbursements disbursed to the Participant in accordance with this Article VI. The entire amount elected by the Participant on the salary Reduction Agreement as an annual amount for the Plan Year for dental and/or vision care reimbursement less any dental and/or vision care reimbursements already disbursed to the participant for Expenses incurred during the plan year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Limited Purpose Health Care Spending Account (provided that the periodic contributions have been made). Thus, the maximum amount of Limited Purpose Health Care Reimbursement at any particular time during the Plan Year will not be related to the amount that a Participant has had credited to his Limited Purpose Health Care Spending Account. In no event will the amount of Limited Purpose Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Limited Purpose Health Care Reimbursement. The Participant must be actively contributing to the account in order to be eligible to receive reimbursement. A Participant who is on an unpaid leave of absence, or terminates employment is no longer actively contributing, and therefore, is not eligible to request reimbursements. Any amount credited to the Limited Purpose Health Care Spending Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to

provide Dental and/or Vision Care Reimbursement within the run-out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor or Internal Revenue Service regulations. The maximum annual reimbursement under the Limited Purpose Health Care Spending Account shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

6.03 Dependent Care Spending Account Reimbursement. Each Participant's Dependent Care Spending Account will be credited with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with this Article VI. In the event that the amount in the Account is less than that 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 Dependent Care Spending Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Spending Account. The Participant must be actively contributing to the account in order to be eligible to receive reimbursement. A Participant who is on an unpaid leave of absence, or terminates employment is no longer actively contributing, and therefore, is not eligible to request reimbursements. Any amount allocated to the Dependent Care Spending Account 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 the run-out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement under the Dependent Care Spending Account shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

6.04 Receiving Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents or Eligible Employment Related Expenses incurred by the Participant while he is a Participant during the Plan Year for which the Participant's election is effective provided that the substantiation requirements of Section 6.04 herein are satisfied. If applicable, however, the employer may offer to have the participant choose to make payment for eligible medical expense or eligible employment related expenses with an electronic payment card arrangement. The terms of the electronic payment card arrangement will be set forth in the SPD.

6.05 Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD and provide the required substantiation set forth in the SPD or as otherwise requested by the Plan Administrator (or its designee).

6.06 Repayment of Excess Reimbursements. If, as of the end of the any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.04 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.

6.07 Reimbursement Following Cessation of Participation. Participants in the Health Care Spending Account may submit claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year and before the date of participation in the Plan ceases so long as the claim is submitted prior to the end of the run-out period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Participants in the Dependent Care Spending Account may submit claims for reimbursement for Eligible Employment Related Expenses incurred during the Plan Year and before the date of participation in the Dependent Care Spending Account ceases so long as the claim is submitted prior to the end of the run-out period set forth in the SPD. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) for the Health Care or Dependent Care Spending Accounts shall be treated in accordance with Section 6.01.

6.08 Coordination of Benefits Under the Health Care Spending Account and the Limited Scope Health Care Spending Account. The Health Care Spending Account is intended to pay benefits solely for otherwise unreimbursed medical expenses; The Limited Scope Health Care Spending Account is intended to pay benefits solely for otherwise unreimbursed dental and/or vision expenses. Accordingly, the Health Care Spending Account and the Limited Scope Health Care Spending Account shall not be considered group health plans for coordination of benefits purposes, and the plans' benefits shall not be taken into account when determining benefits payable under any other plan.

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

6.10 Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

6.11 Statements. The Plan Administrator or its designated third-party administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing reimbursements under the Health Care Spending Account, the Limited Scope Health Care Spending Account and/or Dependent Care Spending Account.

6.12 Post-Mortem Payments. Any benefit payable under the Health Care Spending Account, the Limited Scope Health Care Spending Account or Dependent Care Spending Account 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.

6.13 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.

6.14 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.

6.15 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.

6.16 Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Plan 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 intended to be operated as a self-insured medical reimbursement plan under Code § 105 or a self-dependent care assistance plan under Code § 129.

6.17 Forfeiture of Unclaimed Reimbursement Account Benefits. Any Health Care, Limited Scope Health Care or Dependent Care Spending Account 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, Dental or Vision Expense or Eligible Employment Related Expense was incurred shall be forfeited.

ARTICLE VII
PLAN ADMINISTRATION

7.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that 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 SPD issued in connection with the Plan. 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. Such entity will be referred to as a third-party administrator and shall be identified in the SPD;

(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; and

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

7.02 Provision for Third Party Administrators. 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 may rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the SPD as a third-party administrator. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

7.03 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.

7.04 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 the Employer shall pay all reasonable expenses incurred in the performance of their duties.

7.05 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.

7.06 Payment of Administrative Expenses. The Employer currently pays all reasonable expenses incurred in administering the Plan.

7.07 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 Benefit Plan Options offered under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that 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 that 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.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

ARTICLE VIII
FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements, and/or Non-elective Contributions provided by the Employer, if any. 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.

ARTICLE IX
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pretax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in costs or coverage; or eligibility and participation matters under this Cafeteria plan document) and to the extent offered under the Plan, claims for benefits under the Flexible Spending Accounts.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.01 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 10.02 and 10.03, 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.

10.02 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 Employer in accordance with its normal procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan 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 approved and adopted by any Affiliated Employer.

10.03 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 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.

10.04 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.

ARTICLE XI
GENERAL PROVISIONS

11.01 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.

11.02 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 Controlling Law, as set forth in the Plan Information Appendix of the SPD, to the extent not preempted.

11.03 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.

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

11.05 Tax Effects. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pretax Contributions 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 intended to operate as a "cafeteria plan" under Code § 125.

11.06 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.

11.07 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.

11.08 Incorporation by Reference. The actual terms and conditions of the separate component Benefit Plan 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. In addition, the SPD for this Plan contains many of the actual terms and conditions of this Plan. To that end, the SPD as amended from time to time, is incorporated herein.

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

11.10 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 Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XII
CONTINUATION COVERAGE UNDER COBRA

The SPD includes COBRA continuation of coverage provisions that shall be applicable to the Health Care Spending Account and the Limited Scope Health Care Spending Account, if offered under the Plan, to the extent the plan sponsor is subject to COBRA (as it amended the Code and the Public Health Service Act).

ARTICLE XIII
HIPAA PRIVACY AND SECURITY

13.01 Scope and Purpose. The Health Care Spending Account and the Limited Scope Health Care Spending Account (the "Plans" 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 Plans will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as set forth below.

13.02 Effective Date. This Article XIII is effective on April 14, 2003 or such later effective date of the Privacy Rules with respect to the client.

13.03 Use and Disclosure of PHI.

a) General. The Plans will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plans.

b) Disclosure to the Employer. The Plans will disclose PHI to the Employer, or where applicable, an Affiliate only upon receipt of written certification from the Employer that:

i. The Plan document has been amended to incorporate the provisions in this Article XIII; and

ii. The Employer agrees to implement the provisions in Section 13.04 herein.

13.04 Conditions Imposed on Employer. Notwithstanding any provision of the Plans to the contrary, the Employer agrees:

a) Not to use or disclose PHI other than as permitted or required by this Article XIII or as required by law;

b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plans agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plans;

c) Not use or disclose an Individual's PHI for employment related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;

d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;

e) To report to the Plans any use or disclosure of PHI that is inconsistent with this Article XIII, if it becomes aware of an inconsistent use or disclosure;

f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

h) To make available the information required to provide an accounting of disclosure in accordance with 45 C.F.R. § 154.528;

i) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of Health and Human Services for purposes of determining the Plans' compliance with HIPAA;

j) If feasible, to return or destroy all PHI received from the Plans that the Employer maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

k) To ensure adequate separation between the Plans and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article XIII.

13.05 Designated Employees Who May Receive PHI. In accordance with the Privacy Rules, only certain Employees who perform Plan administrative functions may be given access to PHI. Those Employees who have access to PHI from the Plans are listed in the Privacy Notice, either by name or individual position.

13.06 Restrictions on Employee with Access to PHI. The employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan Administration functions that the Employer performs for the Plans, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing auditing, and monitoring.

13.07 Policies and Procedures. The Employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

13.08 Organized Health Care Arrangement. The Plan Administrator intends the Plans to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

13.09 Privacy Official. The Plan shall designate a Privacy Official, who will be responsible for the Plans' compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultant, or other third-party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plans to the contrary, the Privacy Official shall have the authority to and be responsible for:

a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article XIII;

b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;

c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plans with the requirements of HIPAA;

d) Establishing and overseeing proper training of the Plans, or Employer personnel who will have access to Protected Health Information;

e) Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article XIII.

13.10 Noncompliance. The Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article XIII.

13.11 Definitions. As used in this Article XIII, each of the following capitalized terms shall have the respective meaning given below:

"Individual" means the person who is the subject of the health information created, received or maintained by the Plans or Employer.

"Organized Health Care Arrangement" means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.

"Privacy Notice" means the notice of the Plans' privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

"Privacy Rules" means the privacy provisions of HIPAA and the regulation in 45 C.F.R. Parts 160 and 164.

"Protected Health Information or PHI" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

13.12 Interpretation and Limited Applicability. This Article XIII serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article XIII nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under these Plans, nor shall they insure to the benefit of any third parties. To the extent that any of the provisions of this Article XIII are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

13.13 Services Performed for the Employer. Notwithstanding any other provision of these Plans to the contrary, all services performed by a business associate for the Plans in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plans and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plans performs any services that relate to eligibility and enrollment to the Plans, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plans.

13.14 Security of Electronic PHI. Effective the date that HIPAA's security regulations apply to the HCSA and/or the LSHCSA, the Employer will ensure the following with respect to electronic PHI:

a) That administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the plan are implemented in accordance with the applicable rules and regulations under HIPAA.

b) That reasonable and appropriate security measures are implemented to support adequate separation as required by Section 13.03(k) herein.

c) That any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer under this Section 13.13.

d) That any security incidents of which it becomes aware that are inconsistent with this Section 13.14 are reported to the Plan.

The Plan shall also designate a Security Official, who will be responsible for the Plans' compliance with the security provisions of HIPAA. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third-party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of these Plans to the contrary, the Security Official shall have the authority to and be responsible for:

(a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article VII;

(b) Transmitting the certification to any third parties as may be necessary to permit them to disclose electronic PHI to Employer;

(c) Establishing and implementing policies and procedures with respect to electronic PHI that are designed to ensure compliance by the Plans with the security requirements of HIPAA;

(d) Establishing and overseeing proper training of the Plans, or Employer personnel who will have access to electronic PHI;

(e) Any other duty or responsibility that the Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the security provisions of HIPAA and the purposes of this Article VIII.

The Plans shall also notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

(1) The names of the individuals whose PHI was involved in the Breach;

(2) The circumstances surrounding the Breach;

(3) The date of the Breach and the date of its discovery;

(4) The information Breached;

(5) Any steps the impacted individuals should take to protect themselves;

(6) The steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

(7) A contact person who can provide additional information about the Breach.

The Plans will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

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

COUNTY OF SAN DIEGO

By:_____

Title:_____

Date:_____