NEVADA SYSTEM OF HIGHER EDUCATION

CAFETERIA BENEFITS PLAN
# TABLE OF CONTENTS

## ARTICLE 1

| 1.1 Purpose of Plan | 1.2 Cafeteria Plan Status | 1.3 Exclusive Benefit of Participants | 1.4 Non-Discrimination Requirements | 1 |

## ARTICLE 2

| 2.1 Administrator | 2.2 Change in Status | 2.3 COBRA | 2.4 Code | 2.5 Compensation | 2.6 Dependent Care Expense Reimbursement Plan | 2.7 Dependent | 2.8 Disability Insurance Plan | 2.9 Effective Date | 2.10 Employee | 2.11 Employer | 2.12 Highly Compensated Employee (or HCE) | 2.13 HIPAA | 2.14 Key Employee | 2.15 Life Insurance Plan | 2.16 Medical Care Expense Reimbursement Plan | 2.17 Medical Insurance Plan | 2.18 Participant | 2.19 Plan | 2.20 Plan Year | 2.21 Premium Conversion Plan | 2.22 QMOSO | 2.23 Qualifying Reimbursement Expenses | 1 |

## ARTICLE 3

| 3.1 Eligibility Requirements | 3.2 Entry Date | 3.3 Eligible Classes of Employees | 3.4 Cessation of Participation | 3.5 Reinstatement of Former Participant | 4 |

## ARTICLE 4

| 4.1 Benefit Payment Option | 4.2 Election of Medical and Dependent Care Expense Reimbursement in Lieu of Cash | 4.3 Election of Cash in Lieu of Premium Payments | 4.4 Election Procedure | 4.5 Failure to Elect | 4.6 Changes by Administrator | 4.7 Irrevocability of Election by the Participant | 4.8 Events Permitting Exception to Irrevocability Rule | 4.9 Reimbursable Expenses on Termination of Participation | 4.10 Amount and Form of Payment | 4.11 Automatic Termination of Election | 5 |

## ARTICLE 5

| 5.1 Payment of Benefits | 5.2 Limitations | 5.3 Construction | 5.4 Reports to Employees | 14 |

## ARTICLE 6

|  | 14 |
ARTICLE 1
INTRODUCTION

1.1 Purpose of Plan
The Employer has adopted this Plan to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for eligible Employees and their dependents and beneficiaries. This Plan is designed to permit eligible Employees to choose certain benefits in place of receiving cash.

1.2 Cafeteria Plan Status
This Plan is intended to qualify as a "Cafeteria Plan" under Code §125, and is to be interpreted in a manner consistent with the requirements of that Section.

1.3 Exclusive Benefit of Participants
This Plan has been established for the exclusive benefit of the Participants and their beneficiaries.

1.4 Non-Discrimination Requirements
It is the intent of this Plan and the underlying benefits not to discriminate with respect to contributions and benefits. In determining if any contribution or benefit hereunder is considered discriminatory, the rules in Code §125 and the regulations thereunder shall apply as well as any other applicable Code section or regulation.

ARTICLE 2
DEFINITIONS

2.1 Administrator
The term “Administrator” means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 Change in Status
The term “Change in Status” means any of the events described below, as well as any other events included under subsequent changes to Code §125 or the regulations issued thereunder, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

(a) Change in Marital Status. A change in a Participant’s legal marital status, including marriage, death of the Participant's spouse, divorce, legal separation or annulment.

(b) Change in Number of Dependents. Events that change the number of Dependents, including birth, death, adoption, and placement for adoption.

(c) Change in Employment Status. Any of the following events that change the employment status of a Participant or his or her spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility criteria of this Plan or other employee benefit plan of the Participant, the Participant's spouse or Dependent depend on the employment status of that individual and there is a change in his or her status with the consequence that the individual becomes or ceases to be eligible under this Plan or other employee benefit plan.
(d) **Change in Dependent Eligibility Requirements.** Any event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as a specified age, student status, or any similar circumstance.

(e) **Change in Residence.** A change in the place of residence of the Participant, the Participant's spouse or Dependents.

2.3 **COBRA**
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.4 **Code**
The term "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.5 **Compensation**
The term "Compensation" means wages within the meaning of Code §3401(a) and all other payments of Compensation that are actually paid or made available in gross income during the Plan Year to an Employee by the Employer (in the course of the Employer's trade or business) for which the Employer is required to furnish the Employee a written statement (Form W-2) under Code §6041(d), §6051(a)(3) and §6052. Compensation must be determined without regard to any rules under Code §3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Code §3401(a)(2)). The Administrator may, on a nondiscriminatory basis, elect to include or exclude as Compensation amounts not currently includible in gross income by reason of Code §125, §132(f)(4), §402(e)(3), §402(h), or §403(b). Compensation will not include a Participant's Compensation earned prior to becoming a Participant in the Plan.

2.6 **Dependent Care Expense Reimbursement Plan**
The term "Dependent Care Expenses Reimbursement Plan" means the Dependent Care Expense Reimbursement Plan set forth in Article 5 of the Plan.

2.7 **Dependent**
The term "Dependent" means, for purposes other than the Dependent Care Expense Reimbursement Plan, any person who is a tax dependent of the Participant under Code §152, except that any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more half of the child's support for the calendar year) will be treated as a Dependent of both parents. Notwithstanding the foregoing, the Medical Care Expense Reimbursement Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

For purposes of the Dependent Care Expense Reimbursement Plan, the term Dependent means (a) a dependent of the Participant under age 13 who qualifies as a dependent for income tax purposes; (b) a spouse of the Participant who is physically or mentally unable to care for himself or herself; (c) a dependent of the Participant who is unable to care for himself or herself and who qualifies as a dependent for income tax purposes; and (d) a dependent of the Participant over age 13 if such dependent regularly spends at least 8 hours per day in the Participant's household.

2.8 **Disability Insurance Plan**
The term "Disability Insurance Plan" means a Disability Insurance Plan maintained by the Employer to provide coverage for Employees in the event of disability. The Employer may substitute, add, subtract or revise at any time the benefits, terms and conditions of such plan, and
any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference in this Plan.

2.9 **Effective Date**
The term “Effective Date” means July 1, 2006. The original Effective Date of this amended and restated Plan was July 1, 1999.

2.10 **Employee**
The term “Employee” means any individual who is employed by the Employer or is employed by a related employer that has adopted this Plan.

2.11 **Employer**
The term “Employer” means Nevada System of Higher Education and any other entity which adopts the Plan with the consent of the Employer.

2.12 **Highly Compensated Employee (or HCE)**
The term "Highly Compensated Employee" or "HCE" means, for Plan Years beginning after December 31, 1996, any Employee (a) who during the Plan Year or the look-back year was a 5% owner as defined in Code §416(i)(1); or (b) who for the look-back year had Code §415 Compensation in excess of $80,000 as adjusted under Code §415(d) (except that the base year will be the calendar quarter ending September 30, 1996). The determination of who is a Highly Compensated former Employee is based on the rules for determining HCE status as in effect for the Plan Year or the look-back year for which the determination is being made, in accordance with Temporary Regulation §1.414(q)-1T. A-4 and Notice 97-45. In determining if an Employee is a Highly Compensated Employee for Plan Years beginning in 1997, amendments to Code §414(q) are treated as being in effect for Plan Years beginning in 1996.

2.13 **HIPAA**
The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

2.14 **Key Employee**
The term “Key Employee” means any Key Employee as defined in Code §416(i)(1).

2.15 **Life Insurance Plan**
The term “Life Insurance Plan” means a group term life insurance plan which is maintained by the Employer through which an Employee can obtain up to $50,000 face amount of life insurance coverage. The Employer may substitute, add, subtract or revise at any time the benefits, terms and conditions of such plan, and any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference in this Plan.

2.16 **Medical Care Expense Reimbursement Plan**
The term “Medical Care Expense Reimbursement Plan” means the Medical Care Expense Reimbursement Plan set forth in Article 6.

2.17 **Medical Insurance Plan**
The term “Medical Insurance Plan” means any medical insurance plan maintained by the Employer. The term will also mean drug prescription plans, vision plans, dental plans or other plans providing medical or wellness benefits to the Employee. The Employer may substitute, add, subtract or revise at any time the benefits, terms and conditions of such plan, and any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference in this Plan.
2.18 Participant
The term "Participant" means any Employee who participates in the Plan in accordance with the eligibility requirements set forth in Article 3.

2.19 Plan
The term "Plan" means the Nevada System of Higher Education Cafeteria Benefits Plan as set forth herein, together with any and all amendments and supplements hereto.

2.20 Plan Year
The term "Plan Year" means July 1st to June 30th.

2.21 Premium Conversion Plan
The term "Premium Conversion Plan" means the provision of the Plan under which premiums are paid by Participants for certain insured benefits on a before-tax basis.

2.22 QMCSO
The term "QMCSO" means a qualified medical child support order.

2.23 Qualifying Reimbursement Expenses
The term "Qualifying Reimbursement Expenses" means expenses which qualify under the Internal Revenue Code for reimbursement under this Plan, and which are not otherwise deducted on the Participant's income tax return or reimbursed by insurance.

ARTICLE 3
PARTICIPATION

3.1 Eligibility Requirements

(a) Medical and Dependent Care Expense Reimbursement Plan. With regard to benefits described in Section 4.1(a), an Employee who is a member of an eligible class of Employees as described in Section 3.3 will be eligible to enter the Plan as a Participant on the Entry Date coinciding with or next following his or her date of hire.

(b) Premium Conversion Plan. With regard to benefits described in Section 4.1(b), an Employee who is a member of an eligible class of Employees as described in Section 3.3 will be eligible to enter the Plan as a Participant with regard to such benefits on the same date as he or she becomes eligible to participate in the Medical, Life and Disability Insurance Plans.

3.2 Entry Date
The Entry Date is the first day of the month following the date the Participant meets the applicable eligibility requirements.

3.3 Eligible Classes of Employees
Employees who are considered benefits eligible employees pursuant to Nevada Revised Statutes Section 287.045 or Title 4, Chapter 3 of the Board of Regents handbook are eligible to participate in the Plan.
3.4 Cessation of Participation

(a) Events That Occasion Cessation of Participation. A Participant will cease to be a Participant as of the earlier of (1) the date on which the Plan terminates; (2) the date of his or her termination of employment; or (3) the first day of the Plan Year following the filing of a waiver of Plan participation with respect to all benefit options.

(b) Participants on Certain Leaves of Absence. Participants who take a leave of absence either under the Family Medical Leave Act or the Uniform Services Employment or Reemployment Rights Act may elect to continue participation in the Plan during their period of leave. Participants and their Dependents eligible for coverage under the Medical Care Expense Reimbursement Plan who are otherwise eligible to continue coverage under the Medical Insurance Plan of the Employer pursuant to COBRA may continue to participate in the Medical Expense Reimbursement Plan during such period of coverage. Amounts previously deferred which would otherwise continue to be deferred under this section if the Participant were still employed may be paid to the Plan (1) as a single lump sum at the beginning of each year (or expected leave period), or (2) as monthly payments.

3.5 Reinstatement of Former Participant
A former Participant will become a Participant again if and when the eligibility requirements of Section 3.1 are met, but such Employee cannot commence participation until the first day of the Plan Year in which the Employee is rehired. However, if the former Participant returns to employment with the Employer within 30 days of his or her cessation of employment, the Employee's prior elections will be reinstated.

ARTICLE 4
OPTIONAL BENEFITS

4.1 Benefit Payment Option

(a) Expense Reimbursement Benefit. Participants may choose under this Plan to receive their full Compensation for any Plan Year in cash or to have their Compensation reduced and applied by the Employer toward the cost of the following optional benefits: Dependent Care Expense Reimbursement and Medical Care Expense Reimbursement.

(b) Insured Benefit. A Participant may also choose to receive his or her full Compensation for any Plan Year, not reduced under the preceding paragraph, in cash to be used to pay insurance premiums on an after-tax basis, or to have a portion of his or her Compensation applied by the Employer toward his or her share of the cost of benefits payable under the Medical, Life and Disability Insurance Plans on a before-tax basis. Such Insurance Plans are hereafter referred to as the "Premium Conversion Plan".

4.2 Election of Medical and Dependent Care Expense Reimbursement in Lieu of Cash
A Participant may elect under this Plan to receive one or more of the optional benefits described in Section 4.1(a) in accordance with the procedure described in Section 4.4(a). If a Participant elects an optional benefit described in Section 4.1(a), the Participant's cash compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to a reimbursement account in accordance with Articles 5 and 6.
4.3 Election of Cash in Lieu of Premium Payments

A Participant may elect under this Plan to receive one or more of the optional benefits described in Section 4.1(b) in accordance with the procedure described in Section 4.4(b). If a Participant elects an optional benefit described in Section 4.1(b), the Participant's cash compensation will be reduced, and an amount equal to the reduction will be used to pay premiums for medical, life and disability insurance on a before-tax basis. If a Participant does not elect an optional benefit described in Section 4.1(b), the Participant's cash compensation will be reduced on an after-tax basis and used to pay such insurance premiums.

While a Participant may elect under this Plan to reduce his or her Compensation to pay for his or her share of premiums under the Medical, Life and Disability Insurance Plans, the benefits will be provided not by this Plan but by the Medical, Life and Disability Insurance Plans. The types and amounts of benefits available under these insurance plans, requirements for participating in such plans, and the other terms and conditions of coverage and benefits are as set forth in the Medical, Life and Disability Insurance Plans and in the group insurance contracts and prepaid health plan contracts that constitute, or are incorporated by reference in, the Medical, Life and Disability Insurance Plans. The benefit descriptions in such Medical, Life and Disability Insurance Plans and contracts, as in effect from time to time, are incorporated by reference in this Plan.

4.4 Election Procedure

(a) Coverage Date of Optional Benefits Described in Section 4.1(a). The optional benefits described in Section 4.1(a) will become effective with respect to each Participant as of the beginning of the first pay period for which a salary reduction agreement will apply, if elected by a Participant under the procedures described in this Section. Approximately 60 days prior to the commencement of each subsequent Plan Year, the Administrator will provide one or more written election forms, waiver forms and salary reduction agreements to each Participant and to each other Employee who is expected to become a Participant at the beginning of the Plan Year. Each Participant who desires one or more optional benefit coverage described in Section 4.1(a) for the Plan Year will specify the coverage and the amount of reduction in compensation applicable to each such coverage on the appropriate election form or forms and will agree to a reduction in salary equal to the total of the amounts specified for each such optional benefit. The reduction in the Participant's salary for the Plan Year for each optional benefit described in Section 4.1(a) will be the amount elected by the Participant, subject to the limitations in Section 4.10. Each election form and salary reduction agreement must be completed and returned to the Administrator on or before such date as the Administrator will specify, which date will be no later than the beginning of the first pay period for which the Participant's salary reduction agreement applies.

(b) Coverage Date of Optional Benefits Described in Section 4.1(b). The optional benefits described in Section 4.1(b) will, for the initial Plan Year commencing on the Effective Date, be deemed to become effective for each Employee who is participating in the Medical, Life and Disability Insurance Plans on that date. For all other Employees, Participation will be deemed to be effective on the date provided for in Article 3. Prior to the commencement of each subsequent Plan Year, the Administrator will make available written waiver forms to any Employee who chooses to waive the benefits under Section 4.1(b). An election to waive the benefits must be completed and returned to the Administrator on or before such date as the Administrator will specify, which date will be no later than the beginning of the first pay period for the Plan Year in which the Participant seeks to waive the benefits. An Employee who waives such benefits can participate in the Plan with respect to such benefits for future Plan Years by filing a
written election to participate before any such future Plan Year. The waiver will be effective as of the first day of the Plan Year after the waiver form was filed with the Administrator. Any Employee who is participating in the Medical, Life and Disability Insurance Plans who does not timely file an election to waive his or her participation under this Plan with respect to such benefits will have premium payments under the Medical, Life and Disability Insurance Plans paid through this Plan and will be deemed to have agreed to a reduction in Compensation. The reduction in Compensation for the Plan Year for each premium payment described in Section 4.1(b) will equal the Participant's share of the cost of such Medical, Life and Disability Insurance Plan coverage, and will be adjusted automatically in the event of a change in such cost. The maximum amount of Compensation reduction a Participant can elect cannot exceed the amount of the Participant's share of the cost of Medical, Life and Disability Insurance Plan coverage.

4.5 Failure to Elect

(a) Failure to Elect Optional Benefits Described in Section 4.1(a). An Employee who fails to return a completed election form to the Administrator relating to the optional benefits described in Section 4.1(a) on or before the specified due date for the initial Plan Year of the Plan or for the Plan Year in which he or she becomes a Participant will be deemed to have elected to receive his or her full Compensation in cash. For subsequent Plan Years, a Participant who fails to return a completed election to the Administrator relating to such optional benefits on or before the specified due date for any Plan Year will be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during the preceding Plan Year.

(b) Failure to Elect Optional Benefits Described in Section 4.1(b). An Employee who fails to return a completed election form to the Administrator relating to the optional benefits described in Section 4.1(b) on or before the specified due date for the initial Plan Year of the Plan or for the Plan Year in which he or she becomes a Participant will be deemed to have elected to have the applicable insurance premiums paid on a before-tax basis. For subsequent Plan Years, the Participant who fails to return a completed waiver or election form, as applicable, to the Administrator related to such benefits on or before the specified due date for any Plan Year will be deemed to have elected to continue the election in effect during the preceding Plan Year for the subsequent Plan Year.

(c) Failure to Elect When First Eligible. An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the Entry Date coincident with or next following the date the eligibility requirements are met. The election will be made by submitting an election form to the Administrator at least 10 days before the Entry Date unless the Entry Date is the date of hire, in which case, as soon as practicable after the hire date. An Employee who does not elect to participate when first eligible may not enroll until the beginning of the next Plan Year.

4.6 Changes by Administrator

The Plan will not discriminate in favor of HCEs as to eligibility to participate or as to contributions and benefits, and no more than 25% of the non-taxable benefits paid under the Plan during any Plan Year will be paid to Participants who are Key Employees. If the Administrator determines before or during any Plan Year that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator will take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such

-7-
requirement or limitation. Such action may include, without limitation, a modification of elections by HCEs or Key Employees with or without the consent of such Employees.

4.7 Irrevocability of Election by the Participant

(a) **Elections Are Irrevocable Subject to a Participant’s Change in Status.** Elections made or deemed to be made under the Plan will be irrevocable during the Plan Year, subject to a Change in Status. A Participant may revoke a benefit election for the balance of a Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a Change in Status. Any new election will be effective at such time as the Administrator prescribes, but not earlier than the first pay period beginning after an election form is completed and returned to the Administrator.

(b) **Forfeiture of Unapplied Salary Reduction Amounts.** The amount of any salary reduction amounts not applied against medical and dependent care expenses will be forfeited by the Participant and will be used to defray the reasonable expense of administering this Plan as set forth in Section 7.4.

(c) **Continued Reduction of Compensation and Forfeiture of Unapplied Amounts.** If a Participant ceases or changes the extent of his or her participation in the Medical, Life and Disability Insurance Plans of the Employer for any reason other than a Change in Status, the Participant’s Compensation will continue to be reduced by an amount equal to that portion of the premiums previously payable during such Plan Year for benefits under the Medical, Life and Disability Insurance Plans. The amount of any reduction not applied towards payment of premiums will be forfeited by the Participant and used to defray the reasonable expense of administering the Plan. The amount of Compensation reduction will automatically be adjusted for substantial increases or decreases of coverage.

4.8 Events Permitting Exception to Irrevocability Rule

(a) **Change in status.** A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if the change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or under a plan of the employer of the Participant’s spouse or Dependent (the “general consistency requirement”). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the employer of the Participant’s spouse or Dependent includes a Change in Status that results in an increase or decrease in the number of an Employee’s family members (i.e., a spouse and/or Dependents) who may benefit from the coverage. Election changes may not be made to reduce Medical Reimbursement Expense Care coverage during a Plan Year; however, election changes may be made to cancel Medical Reimbursement Expense Care coverage completely due to the death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Medical Care Expense Reimbursement coverage; or a Dependent’s ceasing to satisfy eligibility for Medical Expense Reimbursement coverage due to attaining a certain age.

1. **Loss of Spouse or Dependent Eligibility - Special COBRA rules.** For a Change in Status involving a Participant’s divorce, annulment or legal separation from a spouse, the death of a Participant’s spouse or a Dependent, or a Dependent’s ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (A)
the spouse involved in the divorce, annulment or legal separation; (B) the deceased spouse or Dependent; or (C) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. If the Participant or his or her spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under state law, under the Employer’s plan, the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant’s Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation.

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

(3) **Special Consistency Rule for Dependent Care Reimbursement Plan Benefits.** With respect to Dependent Care Reimbursement Plan benefits, a Participant may change or terminate his or her election upon a Change in Status if (A) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer’s plan; or (B) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Reimbursement Expenses for the tax exclusion under the provisions of Code §129.

(4) **Special Consistency Rule for Life Insurance.** For any Change in Status, a Participant may elect either to increase or decrease his or her election for life insurance benefits, as applicable.

(b) **HIPAA Special Enrollment Rights.** If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan as required under Code §9801(f) or under the provisions of HIPAA, a Participant may revoke a prior election for group health plan coverage and make a new election, provided the election change corresponds with the HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise under the following circumstances:

(1) **No Enrollment in Group Health Plan Coverage.** If a Participant or his or her spouse or Dependent declines to enroll in group health plan coverage because he or she has other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions were terminated: or

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

(c) Certain Judgments, Decrees and Orders. This paragraph applies to Premium Conversion Plan Benefits that provide accident or health coverage and to Medical Care Expense Reimbursement benefits, but not to Dependent Care Expense Reimbursement benefits. If a judgment, decree, or order (an “Order”) resulting from a divorce, legal separation, annulment or change in legal custody (including a QMSCO) requires accident or health coverage, including an election for Medical Care Expense Reimbursement benefits, for a Participant’s Dependent child, a Participant may (1) change his or her election to provide coverage for the Dependent child provided that the Order requires the Participant to provide coverage; or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual provide coverage under that individual’s plan, and such coverage is actually provided.

(d) Medicare and Medicaid. This paragraph applies to Premium Conversion Plan Benefits that provide accident or health coverage and to Medical Care Expense Reimbursement benefits as limited below, but not to Dependent Care Expense Reimbursement benefits. If a Participant or his or her spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid, the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant’s Medical Care Expense Reimbursement coverage may be canceled but not reduced. Further, if a Participant or his or her spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant’s Medical Care Expense Reimbursement coverage may commence or increase.

(e) Changes in Cost. This paragraph applies to Premium Conversion Plan benefits and to Dependent Care Expense Reimbursement benefits, but not to Medical Care Expense Reimbursement benefits. For purposes of this Section, the term “similar coverage” means coverage for the same category of benefits for the same individuals, e.g. family to family or single to single. For purposes of this definition, (1) Medical Expense Reimbursement Plan coverage is not similar coverage with respect to an accident or health plan that is not a Medical Expense Reimbursement Plan; (2) a health maintenance organization and a preferred provider organization are considered to be similar coverage; and (3) coverage by another employer, such as the employer of the Participant’s spouse or Dependent, is treated as similar coverage hereunder.

(1) Increase or Decrease for Insignificant Cost Changes. The Administrator, on a reasonable and consistent basis, will automatically increase or decrease an affected Participant’s election contributions to reflect an insignificant increase or decrease to his or her required insurance costs. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine if an increase or decrease is insignificant, based upon all the surrounding facts and circumstances, including, but not limited to the dollar amount or percentage of cost change. All changes to a Participant's election contributions will take place prospectively.
(2) Significant Cost Increases. If the Administrator determines that the cost of a Participant’s accident, health, life or disability plan significantly increases during the Plan Year, the Participant may (A) make a corresponding prospective increase in his or her elective coverage; (B) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another accident or health plan offered by the Employer that provides similar coverage; or (C) drop coverage prospectively if there is no other accident or health plan available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Administrator determines that the cost of any accident, health, life or disability plan significantly decreases during the Plan Year, the Administrator may permit the following election changes: (A) Participants who are enrolled in an accident, health, life or disability plan other than the accident, health, life or disability plan that has a decrease in cost may change their elections on a prospective basis to elect the accident, health, life or disability plan that has decreased in cost; and (B) Employees who are otherwise eligible under Article 3 may elect the accident, health, life or disability insurance plan that has decreased in cost on a prospective basis, subject to the terms and limitations of the accident, health, life or disability plan. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) Limitation on Change in Cost Provisions for Dependent Care Expense Reimbursement Benefits. The above “Change in Cost” provisions apply to Dependent Care Expense Reimbursement benefits only if the cost change is imposed by a Dependent care provider who is not a “relative” of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(a)(1) through (8), incorporating the rules of Code §§152(b)(1) and (b)(2).

(f) Change in Coverage. This paragraph applies to Premium Conversion Plan benefits and to Dependent Care Expense Reimbursement benefits but not to Medical Care Expense Reimbursement benefits. The definition of “similar coverage” as set forth in paragraph (e) above also applies to the provisions of this paragraph (f).

(1) Significant Curtailment. If coverage is “significantly curtailed” as defined below. Participants may elect coverage under another accident, health, life or disability plan that provides similar coverage. In addition, if the coverage curtailment results in a “loss of coverage” as defined below. Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is significant and whether a “loss of coverage” has occurred in accordance with prevailing IRS guidance.

(A) Significant Curtailment Without a Loss of Coverage. If the Administrator determines that a Participant’s coverage under an accident or health plan under this Plan, or the Participant’s spouse’s or Dependent’s coverage under his or her employer’s plan is significantly curtailed without a “loss of coverage” (i.e., when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit) during a Plan Year, the Participant may revoke his or her election
for the affected coverage, and in lieu thereof, prospectively elect coverage under another accident, health, life or disability plan that provides similar coverage. Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) **Significant Curtailment with a Loss of Coverage.** If the Administrator determines that a Participant’s coverage under an accident or health plan under this Plan, or the Participant’s spouse’s or Dependent’s coverage under his or her employer’s plan is significantly curtailed, and such curtailment results in a Loss of Coverage, the Participant may revoke his or her election for the affected coverage and may either elect coverage under another accident, health, life or disability plan that provide similar coverage, or drop coverage if no other accident, health, life or disability plan providing similar coverage is offered by the Employer.

(C) **Definition of Loss of Coverage.** For purposes of this Section, a “Loss of Coverage” is a complete loss of coverage, including (i) the elimination of an accident, health, life, or disability plan; (ii) a health maintenance organization ceasing to be available where the Participant or his or her spouse or Dependent resides; or (iii) a Participant or his or her spouse or Dependent losing all coverage under an accident, health, life or disability plan by reason of an overall lifetime or annual limitation. In addition, the Administrator, in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage: (iv) substantial decrease in the medical care providers available under an accident or health plan, such as a major medical hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in an HMO or preferred provider network; (v) a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant, the Participant’s spouse or the Participant’s Dependent is currently in a course of treatment; or (vi) any other similar fundamental loss of coverage.

(2) **Addition or Significant Improvement of an Accident, Health, Life or Disability Plan Option.** If during the Plan Year the Plan adds a new accident, health, life or disability plan option or significantly improves an existing option, the Administrator may permit the following election changes: (A) Participants enrolled in an option other than the newly-added or significantly improved option may change their election on a prospective basis to elect the newly-added or significantly improved option; and (B) Employees otherwise eligible under Article 3 may elect the newly-added or significantly improved option on a prospective basis, subject to the terms and limitations of the option itself. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of or a significant improvement in an option in accordance with prevailing IRS guidance.

(3) **Loss of Coverage under Other Group Health Coverage.** A Participant can prospectively change an election to add group health coverage for the Participant or his or her spouse or Dependent if such individual loses coverage under any group health coverage sponsored by a governmental or educational institution, including but not limited to the following: (A) a state children’s health insurance
plan under Title XXI of the Social Security Act; (B) a medical care program or an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or (C) a foreign government group health plan.

(4) **Dependent Care Expense Reimbursement Coverage Changes.** A Participant may prospectively change an election that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (A) if the Participant terminates one dependent care service provider and hires a new dependent care service provider; the Participant may change coverage to reflect the cost of the new service provider; and (B) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

4.9 **Reimbursable Expenses on Termination of Participation**
The Participant (or the Participant's estate) will be entitled to Medical and Dependent Care Expense Reimbursement only for expenses incurred within the same Plan Year while a Participant, and paid prior to the 90th day after the date participation in the Plan is terminated, and only if the Participant (or the Participant's estate) applies for such reimbursement on or before the earlier of (a) the 180th day following the date participation in the Plan is terminated, and (b) the last day of September following the close of the Plan Year.

4.10 **Amount and Form of Payment**
The Employer's contributions under the Plan for each Plan Year will consist of the aggregate amount applied to the payment of benefits under Articles 5 and 6 pursuant to the Participant's election, any balance of the amount subject to the election hereinabove described which is paid to the Participant in cash, and the amounts used to pay premiums under Section 4.3. However, in no event can the total annual reimbursements under the Dependent Care Expense Reimbursement Plan exceed $5,000 (or $2,500 in the case of married individuals filing separately). If the spouse is a full-time student for at least five months of the year, the deduction is limited to the spouse's earned income (or if greater, $4,800). The total annual amount which the Participant has an election to defer for medical reimbursement will not exceed $6,000.

4.11 **Automatic Termination of Election**
Elections made or deemed to be made under this Plan will automatically terminate on the date a Participant ceases to be a Participant in the Plan, but coverage or benefits under the Medical, Life and Disability Insurance Plans may continue if and to the extent provided by such Plan. Any Participant who terminates employment and is rehired cannot resume participation in the Plan during the Plan Year in which such termination of employment occurs.

Notwithstanding any provision in the Plan to the contrary, to the extent required by COBRA, a Participant and his or her spouse and Dependents whose coverage terminates under the Medical Care Reimbursement Plan because of a COBRA qualifying event will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Care Reimbursement Plan the day before the qualifying event for the period prescribed by COBRA, subject to all conditions and limitations under COBRA, with premiums to be paid for such coverage on an after-tax basis, unless permitted otherwise by the Administrator on a uniform and consistent basis, but not beyond the current Plan Year. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Care Expense Reimbursement account balance at the time of the COBRA qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified that they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such
COBRA coverage for the Medical Expense Reimbursement Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

ARTICLE 5
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

5.1 Payment of Benefits
The Employer, upon proper written claim by a Participant, will apply any reduction in Compensation elected by the Participant pursuant to Article 4 for the payment of benefits under the Dependent Care Expense Reimbursement Plan hereunder (including any prior reductions then standing to the Participant's credit in the Participant's Dependent Care Expense Reimbursement Account, described in Article 7, subject to Section 5.2) to reimburse the Participant for the cost of Dependent care assistance provided during the period to which such election applies which, if paid by the Participant, would be considered an employment-related expense under Code §212(b)(2). The Administrator may also elect to make payments for the cost of any such Dependent care assistance by making payments directly to the service provider.

No such reimbursement shall be made to the extent that, when taken with other such reimbursements for the Participant's taxable year, it exceeds the lesser of (a) the amounts remaining in the Participant's Dependent Care Reimbursement Account; (b) in the case of a Participant who is not married as of the end of his or her taxable year, that Participant's earned income; (c) in the case of a Participant who is married as of the end of his or her taxable year, the lesser of (1) the Participant's earned income for such taxable year, or (2) the spouse's earned income for such taxable year; or (d) $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules set forth in Code §21(e)(3) and Code §21(e)(4). For purposes of the preceding sentence, "earned income" shall have the meaning provided for in Code §129(e)(2); provided that the provisions of Code §212(d)(2) shall apply in determining the earned income of a spouse who is a student or is incapable of caring for himself or herself. No reimbursement shall be made under this Article 5 for amounts paid or payable to an individual related to the Participant within the meaning of Code §129(c).

5.2 Limitations
No reimbursement will be made for expenses incurred during any Plan Year from a reduction in Compensation made during any other Plan Year.

5.3 Construction
The Dependent Care Expense Reimbursement Plan established in this Article 5 is intended to meet the requirements of Code §129 and the regulations thereunder, and will be interpreted and administered in accordance therewith.

5.4 Reports to Employees
Pursuant to Code §129(d)(7), prior to each February 1st the Administrator will provide each Participant with a statement of the amounts paid to such Participant during the previous calendar year under the Dependent Care Expense Reimbursement Plan.

ARTICLE 6
MEDICAL CARE EXPENSE REIMBURSEMENT PLAN

6.1 Claims for Reimbursement
A Participant who has elected to receive Medical Care Expense Reimbursements for a Plan Year may apply for reimbursement of Qualifying Medical Care Expenses incurred by the Participant
during the Plan Year by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth (a) the amount, date and nature of the expense with respect to which a benefit is requested; (b) the name of the person, organization or entity to which the expense was or is to be paid; (c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant; and (d) the amount recovered or expected to be recovered under any insurance arrangement or other plan, with respect to the expense. Such application will be accompanied by bills, invoices, receipts, cancelled checks or other statements showing the amount of such expenses, together with any additional documentation which the Administrator may request.

6.2 Qualifying Medical Care Expense
Qualifying Medical Care Expense means an expense incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code §213 as allowed under Code §105 and the regulations thereunder (including without limitation amounts paid for hospital bills, doctor and dental bills, and payments for prescription drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under the Plan). The term Qualifying Medical Care Expense will also include the amount expended by a Participant, or by the spouse or Dependent of such Participant, to purchase antacid, allergy medicine, pain reliever, and cold medicine without a physician's prescription, as well as any other amount expended by a Participant, or by the spouse or Dependent of such Participant which would be considered a reimbursable expense under the terms of Revenue Ruling 2003-102. Notwithstanding the foregoing, the term Qualifying Medical Care Expense does not include expenses incurred (a) for other health coverage (such as premiums paid under a plan maintained by the employer of the Participant's spouse or Dependents), and (b) for "qualified long-term care services" as defined in Code §7702B(c).

6.3 Reimbursement or Payment of Expenses
The Employer will reimburse the Participant from the Participant's Reimbursement Account, as described in Article 7 for Qualifying Medical Care Expense incurred during the Plan Year, for which the Participant submits a written application and documentation in accordance with Section 7. The Employer may, at its option, pay any such Qualifying Medical Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant.

6.4 Use Of Debit Cards
Notwithstanding any provision herein to the contrary, the Administrator may elect at any time to provide each Participant with a debit card to be used for the payment of Qualifying Medical Care Expenses hereunder, provided however that each Participant certifies upon enrollment and each Plan Year thereafter that the debit card will be used only for eligible medical expenses and that the cardholder's use of the card is limited to the maximum dollar amount of coverage available the Medical Care Expense Reimbursement Account. If debit cards are issued, all charges to the card except for co-payments, recurring expenses and expenses that can be substantiated at the point of sale are treated as conditional pending confirmation of the expense. When the card is used, the merchant or service provider is paid the full amount of the charge and the cardholder's maximum coverage remaining is reduced by that amount, assuming sufficient coverage is available. To the extent that a payment is made that is not a considered a medical expense, the Participant must repay the Plan for such amount, even if he or she is an Employee. To the extent permitted by applicable state law, the amount can be withheld from the wages of the affected Participant. Finally, future reimbursements can be offset by the amount that must be repaid. The Plan Administrator must also take steps to ensure that no further violations occur, including denial of access to the card until all repayments have been made.
6.5 Limitation On Benefits
Notwithstanding any provision contained in this Medical Care Expense Reimbursement Plan to the contrary, no more than $6,000 may be allocated to a Participant's Medical Care Expense Reimbursement Account.

ARTICLE 7
REIMBURSEMENT ACCOUNTS

7.1 Establishment of Accounts
The Employer will establish and maintain on its books accounts for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Reimbursement Expenses incurred during the Plan Year.

7.2 Crediting of Accounts
There will be credited to a Participant's accounts for each Plan Year, as of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's election and Compensation Reduction Agreement under the Plan. All amounts credited to each such account will be the property of the Employer until paid out pursuant to this Article 7.

7.3 Debiting of Accounts
A Participant's Accounts for each Plan Year will be debited from time to time for any payment under this Article 7 to or for the benefit of the Participant for Qualifying Reimbursement Expenses incurred during such Plan Year. Amounts debited to each such account will be treated as payments of the earliest amounts credited to the account, and not yet paid, under a "first-in/first-out" approach.

7.4 Forfeiture of Accounts
The amount credited to a Participant's accounts for any Plan Year will be used only to reimburse the Participant for Qualifying Reimbursement Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement on or before the last day of September following the close of the Plan Year or 180 days after termination of employment, if earlier. If any balance remains in the Participant's accounts for a Plan Year after all reimbursements hereunder, such balance will not be carried over to reimburse the Participant for Qualifying Reimbursement Expenses incurred during a subsequent Plan Year, and will not be available to the Participant in any other form or manner, but will remain the property of the Employer, and the Participant will forfeit all rights with respect to such balance.

7.5 No Trust Created
The Employer will set up a reserve on its books for the amount credited to each Participant's account, but no assets of the Employer will be specifically set aside for the payment of contributions, withdrawals or distributions hereunder, and references to "credits" and other related terms herein will refer only to the setting up of such a reserve. The Plan does not create a trust in favor of a Participant or any person claiming on a Participant's behalf, and the obligation of the Employer is solely a contractual obligation to make payments due hereunder. In this regard, the balance of any account will be considered a liability of the Employer, and a Participant's right thereto will be the same as that of any unsecured general creditor of the Employer. Neither the Participant nor any other person will acquire any right, title or interest in or to any contribution under the Plan or balance in any account other than the right to the actual payment of contributions, withdrawals and distributions in accordance with the terms of the Plan.
ARTICLE 8
ADMINISTRATION OF PLAN

8.1 Administrator
The administration of the Plan will be under the supervision of the Administrator. It will be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will, in addition to all other powers provided by this Plan, include the following: (a) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan; (b) to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming Plan benefits; (c) to decide all questions concerning the Plan and the eligibility of any person to participate therein; (d) to collect the administrative expenses of the Plan from Plan Participants; (e) to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and (f) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of those responsibilities, any such allocation, delegation or designation to be in writing.

8.2 Examination of Records
The Administrator will make available to each Participant the records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

8.3 Reliance on Tables, Etc
In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators by accountants, counsel or other experts employed or engaged by the Administrator.

8.4 Claims and Review Procedures

(a) **Claims For Medical, Life and Disability Benefits.** Claims for benefits under the Medical, Life and Disability Insurance Plans will be reviewed in accordance with procedures contained in the policies for such Plans and/or the applicable summary plan descriptions.

(b) **Claims For Medical Care Reimbursement and Dependent Care Reimbursement Benefits.** Claims for benefits under the Medical Care Reimbursement Plan and Dependent Care Reimbursement Plan will be reviewed in accordance with the following:

1. **Claims Procedure.** A person believes he or she is being denied a claim for reimbursement may file a claim in writing with the Administrator. If a claim for reimbursement is denied, the claimant will receive a written (or electronic) notice of the denial from the Administrator within 30 days of the Administrator's receipt of the claim, provided all needed information was provided with the claim. The Administrator may use a one-time extension not longer than 15 days if the Administrator needs more time to process the claim. In which case the Administrator will notify the claimant within the 30-day period following the Administrator's receipt of the claim that the 15-day extension is being used. The Administrator will also notify the claimant within the 30-day period if additional information is needed to process the claim before a decision can be made. In which case the claimant will have 45 days to provide the needed information. If
all of the needed information is received within this 45-day time period and the claim is denied, the Administrator will notify the claimant of the denial within 15 days after the needed information is received. If the claimant fails to provide the needed information within this 45-day period, the claim will be denied.

(2) **Contents Of Written Notice Of Denial:** The denial described in subparagraph (1) will be written in a manner calculated to be understood by such person, and will contain (A) specific reasons for the denial, (B) specific reference to pertinent Plan provisions, (C) a description of any additional material or information necessary for such person to perfect such claim and an explanation of why such material or information is necessary, and (D) information as to the steps to be taken if the claimant wishes to submit a request for review.

(3) **First Appeal.** If a claimant disagrees with a claim determination after following the procedures described in subparagraph (1), he or she can contact the Administrator in writing to formally request an appeal. The request should include (A) the name of the patient or dependent; (B) the date or dates of the provided services; (C) the provider’s name; (D) the reason the claimant believes the claim should be paid; and (E) any documentation or other written information to support the request for claim payment. The claimant's first appeal request must be submitted to the Administrator within 180 days after receipt of the claim denial. For appeals under the Medical Reimbursement Plan, a qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Administrator may consult with, or seek the participation of, medical experts as part of the appeal process. The claimant's consent will be sought to this referral and the sharing of pertinent health claim information. Upon request and free of charge, the claimant or his or her representative have the right to reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. The claimant will receive a written (or electronic) notice of the Administrator's decision on the appeal within 30 days from receipt of a request for appeal of a denied claim.

(4) **Second Appeal.** If the claimant is not satisfied with the decision of the Administrator pursuant to the first appeal described above, the claimant will have the right to request a second appeal from the Administrator. This second appeal request must be submitted to the Administrator within 60 days from receipt of first appeal decision. The claimant will receive written (or electronic) notice of the Administrator's decision regarding the second appeal within 30 days of receipt of a request for review of the first appeal decision.

(5) **Contents Of Appeal Decisions.** The decisions on appeal which are described in subparagraphs (3) and (4) above will be written in a manner calculated to be understood by such person, and will contain specific reasons for the denial, specific reference to pertinent Plan provisions, and information as to the steps to be taken if the claimant wishes to take legal action related to his or her claim.
8.5 **Nondiscriminatory Exercise of Authority**
Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator will exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

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

**ARTICLE 9**
**AMENDMENT AND TERMINATION OF PLAN**

9.1 **Amendment or Termination of Cafeteria Plan**
The Plan may at any time be amended or terminated by a written instrument signed by the Employer. Upon termination of the Plan, all elections and reductions in Compensation under the Plan will terminate. Any amounts remaining in a Participant's Reimbursement Account will be reimbursed in accordance with Section 4.9. Any reduction in a Participant's Compensation made prior to termination of the Plan, for purposes of paying that portion of the premiums payable by a Participant for benefits under the Medical, Life and Disability Insurance Plans that were not applied to such payment, will be applied to the next premium payable by the Participant.

9.2 **Amendment or Termination of Insurance Plans**
Nothing contained in the Plan will limit the Employer's right, without notice to or consent from any Employee, to amend or terminate the Medical, Life and Disability Insurance Plans.

**ARTICLE 10**
**MISCELLEANOUS PROVISIONS**

10.1 **Information to be Furnished**
Participants will provide the Employer and Administrator with such information and evidence, and will sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.2 **Limitation of Rights**
Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable rights against the Employer or Administrator, except as provided herein.

10.3 **No Guarantee of Tax Consequences; Indemnification of Employer**
While the Employer intends that the amounts applied to the payment of one or more of the optional benefits described in Section 4.1 will be excludable from the Participant's gross income for federal income tax purposes, neither the Employer nor the Administrator makes any commitment or guarantee that these amounts will be excludable from a Participant's gross income for federal income tax purposes, or that any other federal, state, or local tax treatment will apply. It is the Participant's obligation to notify the Employer if the Participant has any reason to believe that any payment is not excludable from his or her gross income. If any before-tax payment made on behalf of a Participant for one or more of the optional benefits described in Section 4.1 is
disallowed by any federal, state, or local taxing authority, the Participant must indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local taxes that the Participant would have owed if such payment had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation.

10.4 Governing Law
This Plan will be construed, administered and enforced according to the laws of the state in which the Employer maintains its principal place of business.

10.5 Use Of Electronic Media
Notwithstanding anything contained herein to the contrary, in any provisions of this Plan where there is a requirement that a Participant provide a written notice, election or claim for benefit, such requirement may be satisfied by electronic media provided such Participant meets all requirements regarding electronic media as set forth by the Administrator.

10.6 Application Of Plan Surplus
In no event shall any amounts forfeited by a Participant because of failure to submit a claim for reimbursement within the time frame set forth herein be used reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other benefit available under the Plan. Nor shall any amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Forfeited amounts shall be used to defray any administrative costs and experience losses incurred by the Plan.

10.7 HIPAA Privacy Requirements
If HIPAA applies to this Plan, the Plan will protect the confidentiality and privacy of individually identifiable health information, and the Plan and those administering it will use and disclose health information only as allowed by Federal law and only in accordance with a HIPAA Privacy Policy established by the Administrator, the terms of which are incorporated herein by reference.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed in its name and on its behalf as of this 27 day of June, 200_, by its officer thereunto duly authorized.

NEVADA SYSTEM OF HIGHER EDUCATION

By (signature) Title Chancellor
NEVADA SYSTEM OF HIGHER EDUCATION  
CAFETERIA BENEFITS PLAN  
HIPAA PRIVACY POLICY AND PRACTICES

A. LEGAL DUTY TO PROTECT HEALTH INFORMATION

As an employer that provides a health benefit plan (the “Plan”), Nevada System of Higher Education (the “Employer”) is required to protect the privacy of health information about Plan Participants that can be individually identified with the subject. This information is known as protected health information, or “PHI” for short. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that covered entities, including health benefit plans, provide notice of their legal duties and privacy practices concerning PHI, which are best summarized as follows:

- The Plan will protect PHI that it creates or receives about a Participant’s past, present, or future health condition, health care the Plan provides to the Participant, or payment for such health care.
- The Plan will notify Participants about how it will protect the Participant’s PHI.
- The Plan will explain how, when and why it will use and/or disclose PHI about the Participants.
- The Plan may only use and/or disclose PHI as described in this HIPAA Privacy Policy.

In most cases, the Plan does not collect any PHI concerning Participants. In most instances, the Plan simply collects demographic and enrollment data concerning Participants. This type of information is not considered PHI. However, the Plan sometimes collects PHI concerning claims to assist and process denied claim appeals. In these cases, this PHI will be covered by this HIPAA Privacy Policy and Practices (the "Policy").

This Policy describes the types of uses and disclosures that the Plan may make. The Plan may make other uses and disclosures which occur as a byproduct of the permitted uses and disclosures described in this Policy. The Plan reserves the right to change the terms of the Policy and to make new privacy provisions effective for all PHI the Plan maintains. In implementing and enforcing this Policy, the Privacy Officer is the Administrator.

B. USES AND DISCLOSURES OF PHI NOT REQUIRING AUTHORIZATION

1. The Plan may use and disclose PHI about Participants to provide health care treatment. The Plan may use and disclose PHI to provide, coordinate or manage health care and related services. This may include communicating with other health care providers regarding treatment and coordinating and managing health care with others.

2. The Plan may use and disclose PHI to obtain payment for services. Generally, the Plan may use and give medical information to others to bill and collect payment for treatment and services. The Plan may share information about these services with other health plans and health care providers. The Plan may also share portions of medical information with the following:
• Billing departments

• Collection departments or agencies

• Insurance companies, health plans and their agents which provide coverage

• Hospital departments that review the care received to check that it and the costs associated with it were appropriate for the illness or injury

• Consumer reporting agencies (e.g., credit bureaus)

3. The Plan may use and disclose PHI for health care operations. The Plan may use and disclose PHI for business activities ("health care operations"), allowing the Plan to improve the quality of care and reduce health care costs. Examples of PHI uses and disclosures related to "health care operations" include:

• Reviewing and improving the quality, efficiency and cost of the health benefits.

• Improving health care and lowering costs for groups of people who have similar health problems and to help manage and coordinate the care for these groups of people.

• Reviewing and evaluating the skills, qualifications, and performance of health care providers.

• Providing training programs for students, trainees, health care providers or non-health care professionals (e.g., billing clerks or assistants, etc.).

• Cooperating with outside organizations that assess the quality of the care. These organizations might include government agencies or accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA).

• Assisting various people who review the Plan’s activities. For example, PHI may be seen by doctors reviewing the services provided, and by accountants, lawyers, and others who assist the Plan in complying with applicable laws.

• Conducting business management and general administrative activities related to the Plan organization and the services it provides.

• Resolving grievances.

• Reviewing activities and using or disclosing PHI in the event that we sell the Plan, its property or give control of our business or property to another.

• Complying with this Privacy Policy and with applicable laws.

4. Other circumstances. The Plan may use and/or disclose PHI for a number of circumstances without consent, including:
• When the use and/or disclosure is required by law.

• When the use and/or disclosure is necessary for public health activities.

• When the disclosure relates to victims of abuse, neglect or domestic violence.

• When the use and/or disclosure is for health oversight activities.

• When the disclosure is for judicial and administrative proceedings.

• When the disclosure is for law enforcement purposes.

• When the use and/or disclosure relates to decedents.

• When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes.

• When the use and/or disclosure relates to medical research.

• When the use and/or disclosure is to avert a serious threat to health or safety.

• When the use and/or disclosure relates to specialized government functions.

• When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.

5. Participant’s right to object to certain uses and disclosures. Unless a Participant objects in writing, the Plan may use or disclose PHI in the following circumstances:

• The Plan may share with a family member, relative, friend or other person identified by a Participant, PHI directly related to that person’s involvement in a Participant’s care or payment for a Participant’s care. The Plan may share with a family member, personal representative or other person responsible for a Participant’s care PHI necessary to notify such individuals of a Participant’s location, general condition or death.

• The Plan may share with a public or private agency (for example, American Red Cross) PHI about a Participant for disaster relief purposes. Even if the Participant objects, the Plan may still share the PHI, if necessary for the emergency circumstances. Participants who wish to object to the use or disclosure of PHI in the above circumstances should contact the Privacy Officer.

6. The Plan may contact Participants with information about treatment, services, products or health care providers. The Plan may use and/or disclose PHI to manage or coordinate healthcare, including informing Participants about treatments, services, products and other healthcare providers.
7. The Plan may not disclose PHI to persons involved in making employment decisions. The Plan will keep PHI in a locked file cabinet to which only persons with access are those persons who are determined to require such access. The Plan will not disclose PHI to anyone else except the Employer for any reason, unless specifically authorized by a Participant. The Plan may destroy PHI without notice, when the Plan no longer needs to maintain such PHI (i.e., when a claim appeal is fully and finally adjudicated; when a Participant returns to work and/or when short term disability benefits are exhausted).

C. ANY OTHER USE OR DISCLOSURE OF PHI REQUIRES WRITTEN AUTHORIZATION

Under any circumstances other than those listed above, the Plan must ask for the Participant’s written authorization before using or disclosing PHI. If the Participant signs a written authorization allowing disclosure, the Participant can later cancel the authorization both orally and in writing. If cancelled in writing, the Plan will not disclose PHI after cancellation is received, except for disclosures which were being processed before cancellation was received.

D. PARTICIPANTS’ RIGHTS REGARDING PHI

1. Participants have the right to request restrictions on uses and disclosures of PHI. Participants have the right to request that the Plan restrict the use and disclosure of PHI, but the Plan is not required to agree to the requested restrictions. Further, even if the Plan agrees to the request, in certain situations the restrictions may not be followed, including emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. Participants may only request a restriction by writing the Privacy Officer.

2. Participants have the right to request different ways for the Plan to communicate with them. Participants may request how and where the Plan contacts them about PHI. For example, they may request that the Plan contact them at work or by email. The Plan must accommodate reasonable requests, but when appropriate, may condition that accommodation on the Participant providing the Plan with information regarding how payment, if any, will be handled and specification of an alternative address or other method of contact. Participants may only request alternative communications by writing the Privacy Officer.

3. Participants have the right to see and copy their PHI. Participants have the right to request to see and receive a copy of PHI contained in the Plan’s records used to make decisions about them. The request must be in writing. The Plan may charge Participants related fees. Instead of providing a full copy of the PHI, the Plan may give a summary or explanation of the PHI if the Participant agrees in advance to the form and cost of the summary or explanation. There are certain situations in which the Plan is not required to comply with a request to see and copy PHI. The Plan must communicate a denial in writing, stating why the Plan will not grant the request and describing any rights the Participant may have to request a review of the denial. Participants may request to see and receive a copy of PHI by writing the Privacy Officer.
4. **Participants have the right to request an amendment of their PHI.** Participants have the right to request that the Plan make amendments to the PHI in the Plan’s records used to make decisions about Participants. As always, the request must be in writing and must explain the reason or reasons for the amendment. The Plan may deny the request if:

- The PHI was not created by the Plan (unless the Participant can prove the creator of the information is no longer available to amend the record).

- The claimed information is not PHI or part of the records used to make decisions about the Participant.

- The Plan believes the information is correct and complete.

- A Participant would not have the right to see and copy the record as described in paragraph 3.

The Plan will communicate in writing the reasons for the denial and describe the Participant’s rights to insert a written statement disagreeing with the denial. If the Plan accepts the request to amend the information, the Plan will make reasonable efforts to inform others of the amendment, including persons specified by Participant who have received their PHI and who need the amendment. Participants may request an amendment of PHI by writing to the Privacy Officer.

5. **Participants have the right to a listing of disclosures the Plan has made.** If requested in writing, Participants may receive a written list of certain of the Plan’s disclosures of PHI, limited to uses and disclosures for the six years before the request (not including disclosures made prior to April 14, 2003). The Plan will maintain a log for all non-routine uses and disclosures that do not involve any of the following:

- Treatment

- Billing and collection of payment for treatment

- Health care operations

- Made to or requested by a Participant, or authorized by a Participant

- Occurring as a byproduct of permitted uses and disclosures

- Made to individuals involved in Participant’s care (e.g., physicians, hospitals, etc.), for directory or notification purposes, or for other purposes described in subsection B.4 above

- Allowed by law when the use and/or disclosure relates to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations (see subsection B.4 above)

- As part of a limited set of information which is de-individually identifiable (e.g., does not contain certain information which would identify a Participant)
The log will include the following elements:

- The date of the disclosure
- The name (and address, if available) of the person or organization receiving the information
- A brief description of the PHI disclosed
- The purpose of the disclosure

If a Participant requests a list of disclosures more than once in 12 months, the Plan can charge a reasonable fee for such list of disclosures. Participants may request a listing of disclosures by writing the Privacy Officer.

6. Right to a copy of the Plan’s Privacy Notice, Policy and Practices. Participants may request a paper copy of the Plan’s HIPAA Privacy Notice, and this Privacy Policy and Practices at any time by writing the Privacy Officer. Furthermore, the Plan will provide a copy of same no later than the date a Participant first becomes eligible to receive benefits or as soon as practicable thereafter.

7. Right to File a Complaint. Participants who think their privacy rights have been violated, or want to complain about our privacy practices, can contact the Privacy Officer. Participants may also send a written complaint to the United States Secretary of the Department of Health and Human Services. The Plan will not take any action against a Participant or change our treatment of them in any way if they file a complaint.