

KSBJ EDUCATIONAL FOUNDATION INC.

SECTION 125 CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2011

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**KSBJ EDUCATION FOUNDATION INC.
SECTION 125 CAFETERIA PLAN (“the Plan”)**

SUMMARY PLAN DESCRIPTION

**PART I.
PLAN INFORMATION**

I. INTRODUCTION

1.1. Sponsorship of Cafeteria Plan. KSBJ Educational Foundation (“the Employer”) is pleased to sponsor an employee flexible benefit program for you and your fellow employees. Under Section 125 of the Internal Revenue Code, it is also known as a “cafeteria plan”. It is so-called because it allows you to choose from a menu of different insurance and fringe benefit programs according to your individual needs.

1.2. Overview of Plan Operation. Ordinarily, each dollar of compensation you receive is subject to federal income tax. Each dollar of compensation is also reduced by contributions to Social Security (F.I.C.A.) unless your compensation exceeds the Social Security Wage Base (go to www.ssa.gov and click on questions about earnings and employment to obtain the current years maximum wage). This means that if you wish to purchase one or more of the benefits available under the Plan, you must earn enough compensation to pay *both* the cost of the benefits you elect, *and* the tax and F.I.C.A. imposed on your compensation. Thus, if your combined federal income tax and F.I.C.A. rate is 35%, you must earn \$1.54 before tax to pay for each \$1.00 of these benefits. Even if you work for a state or local government organization where certain employees are exempt from Social Security taxes, you are still subject to the Medicare tax of 1.45% of compensation

Under Section 125 of the Internal Revenue Code, an employer may adopt a cafeteria plan under which eligible employees have the opportunity to choose among taxable cash compensation and certain nontaxable fringe benefits through a salary conversion agreement. If you elect to receive cash, you will be taxed as before. If you elect a nontaxable fringe benefit, each dollar of compensation covered by your election is used to purchase or provide those benefits without reduction for federal income taxes or Social Security contributions.

1.3. Summary Plan Description. This document is a summary of the most important features of the Plan. Since this document cannot contain all of the provisions of the Plan, you may wish to obtain a copy of the Plan. *The provisions of the Plan and its amendments are controlling.* Copies of the Plan are available from your Employer, which may charge a fee for copying the Plan.

The benefits you can purchase through the Plan are separate programs which are subject to the terms of insurance policies, documents or other procedures in addition to this Plan. This Summary does not anticipate the terms of these policies. Your Employer will provide you with additional information or summary plan descriptions describing the features of the insurance policies and other Benefit Programs purchased under this Plan. You may review and make copies of these insurance policies themselves by requesting them from the Employer.

1.4. Definitions and Special Terms. The Plan is a complex legal document which incorporates many words and phrases that have specific meanings. The definitions of these words and phrases are defined in the Plan document. Some of these terms may also be briefly defined in this Summary. However, the actual definition of these terms and phrases as presented in the Plan document are controlling. If you have any questions concerning these terms and phrases, you should consult the Plan document or your Employer.

II. PLAN IDENTIFICATION INFORMATION

| | |
|--|---|
| Name of Plan | KSBJ Educational Foundation Section 125 Cafeteria Plan |
| Plan Number | 501 |
| Plan Year | January 1st through December 31st |
| Adopting Employer | KSBJ Educational Foundation Inc. 1722 Treble Drive Humble, Texas 77338 (281) 446-5725 |
| Employer Federal ID Number | 74-2162248 |
| Plan Sponsor | KSBJ Educational Foundation Inc. |
| Plan Administrator | KSBJ Educational Foundation Inc. |
| Agent for Service of Legal Process | KSBJ Educational Foundation Inc. c/o General Manager 1722 Treble Drive Humble, Texas 77338 |
| Effective Date of Plan | January 1, 2009 |
| Date of last Amendment and Restatement | January 1, 2011 |
| Summary Plan Description Revision Date | September 1, 2008 |
| Claims Administrator | JEM Resource Partners, LP 900 S. Capital of Texas Hwy., Ste. 350 Austin, TX 78746 Ph: (800) 943-9179 Fax: (888) 989-9247 JEM Website: www.jemtpa.com |
| Third Party Administrator | JEM Resource Partners, LP |

III. ELIGIBILITY AND PARTICIPATION

3.1. Who can participate in the Plan?

To participate in the Plan, an employee must meet the following eligibility criteria:

must work at least 30 hours per week.

Those employees who actually participate in the Plan are called "Participants". So long as you remain eligible, you may participate in the Plan until your death, termination of employment, disability, or retirement.

3.2. How do I become a Participant?

On or before the time you become eligible to participate in the Plan, the Plan Administrator will provide you with an enrollment form, on which you may agree to convert a portion of your compensation to Cafeteria Plan Dollars to purchase one or more benefits you elect under the Plan. If you do not initially elect to participate in the Plan, you will be provided a new enrollment form during the Open Enrollment Period which precedes the next Plan Year. In future enrollments, you will be given the opportunity to confirm or change your choices made for the previous Plan Year for the upcoming Plan Year.

3.3. When are the Open Enrollment Periods for entering the Plan?

If you are a new employee, you may initially enroll in the Plan on the first payroll date following the date when you have met the eligibility requirements described in 3.1. above. Thereafter, the Open Enrollment Period will begin on December 1st and end on December 31st. Your Employer may change the Open Enrollment Period from year to year; however, you will be notified each year of the dates.

If you elect to waive participation in the Plan either at your date of hire or at any subsequent enrollment period(s), you forfeit your right to participate in the Plan until the *next* Enrollment Date unless the employee qualifies for a Change in Status described in Answer 6.6 of this Summary Plan Description.

3.4. What are the Enrollment Dates of the Plan?

The Enrollment Date is January 1st.

Newly hired employees who meet the eligibility requirements of 3.1. above, may enroll in the plan on the following dates:

- **Flexible Spending Arrangements** first payroll date after hire

3.5. Can I stay in the plan if I am absent on a family medical leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence using one of the following methods:

- *Pre-payment.* Under the pre-payment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.
- *Post-payment.* Under the post-payment option, you may have your Employer continue payments for you while you are on FMLA leave, and increase your salary reduction upon your return to work in an amount sufficient to cover the premiums that occurred during your FMLA leave.
- *Pay-as-you-go.* With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid with pretax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you will have to reimburse the Employer at regular intervals from your after-tax funds for the premiums that come due during the leave.

3.6. What if I am absent from work for duty in the uniformed services?

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will be not interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the plan by paying premiums under any of the two premium payment options described in 3.5 above.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect Continuation Coverage under the Employer's group major medical insurance plan only for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out under that plan.

3.7. What if I terminate my employment during the Plan Year?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. You will have until the 90th day after your termination date in which to submit a claim for eligible expenses incurred by you during the time you were covered under the Plan during the current Plan Year. Reimbursements for pre-termination expenses will be limited to the balance of the annual benefit you elected, reduced by any reimbursements you have already received during the Plan Year.

PART II. BENEFITS

The Employer maintains various health and welfare benefit programs. The purpose of the Plan is to allow you to select a combination of certain of these qualified benefits that best suits your needs. The two main groups of benefits provided through this Plan are 1) flexible spending arrangements for unreimbursed medical expenses; and 2) taxable cash payments in the form of regular salary. The sections in Part II of this Summary describe the benefits which are available through this Plan in detail. The procedures and limitations for allocating your Cafeteria Plan Dollars to the benefits you elect are described in Section VI. of this Summary.

IV. MEDICAL EXPENSE REIMBURSEMENT PLAN

One of the more advantageous programs of the KSJB Educational Foundation Section 125 Cafeteria Plan (the "Plan") is the opportunity for you to elect to receive income tax-free reimbursement for some or all of yours, your spouse's, or your dependents' uninsured medical, dental and vision expenses ("Medical Expenses") under the Flexible Spending Arrangement program known in the Plan as the Medical Expense Reimbursement Plan ("MERP"). Under MERP, you purchase a specific level of medical expense reimbursement benefits, paying for the coverage with Cafeteria Plan Dollars. When you take advantage of this Flexible Spending Arrangement the benefits you elect are nontaxable, and you save social security and income taxes on the amount of the premiums you pay.

Questions & Answers

4.1. Who can participate in the Medical Expense Reimbursement Plan?

Each employee of the Employer who has met the eligibility requirements as defined in Section 3.1 of this Summary.

4.2. How do I become a Participant?

By electing the Medical Expense Reimbursement Plan during the annual Open Enrollment Period.

4.3. What is my "Medical Expense Reimbursement Account"?

If you elect benefits under MERP, a Medical Expense Reimbursement Account ("Account") will be set up in your name to keep a record of the benefits you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year.

4.4. What annual benefits are available under MERP, and how much will they cost?

The maximum amount you may convert to Cafeteria Plan Dollars for MERP is \$1000 per Plan Year. You may choose any amount up to this maximum annual benefit. You will be required to pay the annual premium that corresponds to the benefit level you choose. For example, if you elect \$1200 in MERP benefits, you will be required to pay the annual premium of \$1200 through payroll deductions of \$100/month. You should only elect the amount of benefits you feel you will use for the Plan Year.

4.5. How is my Medical Expense Reimbursement benefit paid for?

When you complete the Salary Conversion Election form, you specify the amount of MERP benefits you wish to pay for with your Cafeteria Plan Dollars. Thereafter, you must pay for this benefit by having an equal portion of the annual amount deducted from each paycheck. These amounts are credited to your MERP Account each pay period by your Employer. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket Medical Expenses at any time during the Plan Year, so long as you continue to be a Participant in MERP.

For example, suppose you elect on January 1st to be reimbursed for up to \$1200 for the year for eligible Medical Expenses, your MERP Account would be credited (funded) by your Employer with a total of \$1200 for the Plan Year. As your election amounts are deducted from your paycheck throughout the Plan

Year, your Account would reflect that you have paid \$100 per month for MERP, eventually totaling \$1200 at the end of the Plan Year, less any reimbursements for claims you received during the year.

4.6. What if I have a \$1200 expense early in the Plan Year, is it reimbursable?

Provided that your paycheck continues to be deducted for the periodic premiums due for this benefit, the full, annual amount of coverage of \$1200 you elected on January 1st will be available as a benefit at any time during the Plan Year, reduced by the amount of any prior reimbursements you received earlier in the Plan Year, regardless of the amount you have paid in premiums to MERP.

4.7. How do I receive my benefits under MERP?

If you elect to participate in MERP, you will be issued a flexible spending account debit card, to use to pay for your out-of-pocket medical expenses at the time of service. The debit card automatically transfers your pre-tax dollars from your MERP Account to the provider to pay for your medical expenses. However, only eligible Medical Expenses may be debited from your Account. You should refer to the Claims Administrator's "Section 125 Cafeteria Plan Booklet" on the JEM Website (see Claims Administrator information on page 2) for a list of qualified Medical Expenses before using your debit card.

4.8. What if I forget to use my debit card? Can I still make a paper claim?

Yes, when you incur an expense that is eligible for reimbursement, you may submit a paper claim to the MERP Claims Administrator on the claim form that is provided on the JEM Website. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit you elected. Your debit card expenses and paper claim expenses will be totaled together to determine the total amount of benefit you have used during the Plan Year.

4.9. What is an "eligible Medical Expense?"

For these purposes, an eligible Medical Expense means expenses for medical care which would be deductible for tax purposes if you paid them directly, including all amounts expended for hospital bills, doctor bills, dental and vision bills, prescription drugs, lab work, and other payments for the treatment or cure of disease or for the purpose of affecting any structure or function of the body. Medical Expenses do not include any expenses subject to reimbursement under any health insurance or health plan maintained by the Employer or any other employer or by government programs.

You should review the list of eligible Medical Expenses included with the Claim Form for assistance in determining what is an "eligible expense", as well as the list provided in the "Section 125 Cafeteria Plan Booklet" on the JEM Website. You are also encouraged to consult your personal tax advisor or IRS Publication 502 "Medical and Dental Expenses" for further guidance as to what is or is not an eligible expense if you have any doubts.

4.10. When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the plan became effective, before your MERP election becomes effective, or for any expenses incurred after the close of the Plan Year.

4.11. Can I be reimbursed for the full amount of my orthodontia contract?

Generally speaking, if your orthodontia contract covers more than 12 months, you may not be reimbursed for the full amount because Internal Revenue Code regulations require that only expenses *incurred* during the Plan Year may be reimbursed. Because a typical orthodontia contract is for monthly services to be rendered over, for example, a 2 or 3 year period, the amount you can be reimbursed will only be for services which would ordinarily be covered within the 12-month Plan Year.

For example, if the Plan Year is January – December, and your orthodontia contract of \$4500 began in June of this Plan Year for a period of 3 years, your claim for the total orthodontia contract will be paid by dividing the total contract by 36 months and multiplying times the number of months left in the Plan Year. The total you could be reimbursed for this Plan Year in the example below would be \$875.00. You could then submit a claim for \$1500 in the next Plan Year, provided you elect MERP as one of your benefits and you continue to be a Participant in the Medical Expense Reimbursement Plan, and so on in the succeeding Plan Years, until your contract has been reimbursed in full.

Example: \$4500 (total contract) ÷ 36 months (contract period) = \$125.00/month
 \$125.00 x 7 months (June – December) = \$875.00
 \$125.00 x 12 months (January – December of next Plan Year) = \$1500

4.12. What if the medical expenses I incur during the Plan Year are less than the annual benefit I elected?

You will not be entitled to receive any refund of any balance left over in your MERP Account at the end of the Plan Year. Any balance left at the end of the Plan Year is forfeited and may be used by the Employer to pay for any future expenses of the Plan.

4.13. How long do I have to make a claim for reimbursement for eligible expenses?

You have 90 days after the end of the Plan Year to make any claims for eligible Medical Expenses. After 90 days, any amounts left in your MERP Account will be forfeited. You may look up any remaining balances and claims on your Account on the JEM Website.

4.14. What is “Use it or Lose it”?

You will receive a report of the balance in your MERP Account from the Claims Administrator 60 days prior to the end of the Plan Year. If you do not use up the balance in the account through legitimate eligible Medical Expenses, AND you do not make claim for these expenses within the 90 day period at the end of the Plan Year (see Answer 4.13), you will lose any amounts left over in your account, i.e., you will forfeit the amounts unused in your MERP Account. See also Answer 4.12.

4.15 Recovery of Overpayments. Whenever payments have been made with respect to eligible expenses in excess of the amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover these excess payments. Further, the Plan Administrator reserves the right to deduct the amount of any excess payments from future benefits to which a Participant or any of his or her dependents may become entitled.

V. CASH BENEFITS

Under Internal Revenue Code regulations, a cafeteria plan will not be qualified unless your Employer offers you the choice of cash, a taxable benefit, and nontaxable benefits such as those provided in the previous sections. When you complete a Salary Conversion Election form, you are choosing between cash and those benefits you elect by converting a portion of your pay to Cafeteria Plan Dollars to purchase one or more nontaxable benefits. Any part of the maximum Annual Benefit Limit defined in Section 7.5. that you do not choose to apply toward the purchase of the nontaxable benefits described below will be deemed as being elected by you to be received as regular, taxable salary.

Questions & Answers

5.1. Can I choose all cash compensation and no fringe benefits?

Yes, under the Salary Conversion Election form, you are offered the opportunity to waive your right to any of the nontaxable benefits. In that case, you will receive that portion of the Annual Benefit Limit provided to you in your wages as taxable income.

5.2. Do I have to choose any cash? May I elect to receive the total benefit limit in fringe benefits?

No, you do not have to choose any amount of the maximum Annual Benefit Limit as cash. You may apply the maximum Annual Benefit Limit towards the purchase of all nontaxable fringe benefits.

VI. CONTRIBUTION AND ELECTION LIMITATIONS

6.1. What are "Cafeteria Plan Dollars"?

For each Plan Year, you may elect to convert a portion of your Compensation, called salary conversion, to purchase various benefits covered by the Plan. Your salary conversion contribution is called your "Cafeteria Plan Dollars." Only Cafeteria Plan Dollars may be used to purchase benefits available under the Plan.

6.2. Is my overtime pay subject to salary conversion?

Under the Plan, any Compensation you receive for overtime, vacation or other paid leave time, bonuses, commissions, as well as your regular salary or wages is subject to conversion to Cafeteria Plan Dollars as necessary in order to meet the monthly premium amounts due for the benefits you elected.

6.3. What if I am a retiring employee or terminating employment, is my contract pay subject to salary conversion?

If you are a contracted employee retiring or otherwise terminating employment at the end of your contract period, for example, August 1- July 31, and you elect to receive a lump sum payment (assuming your Employer allows this election) through the end of your contract on your last day of work (for example, pay due for May 1-July 31 paid on last day of work, May 31) this payment would be considered part of your regular salary, even though it is paid in a lump sum prior to the end of your contract. Any amounts due for the remainder of the contract period could be converted to pay for that period's monthly premiums, assuming you want to continue coverage under the Plan, *AND you don't effectively terminate your employment until the last day of your contract.* If you effectively terminate your employment on May 31, then you cease to be a participant in the Plan on June 1, and your benefit premiums could not be paid with your Cafeteria Plan Dollars through August 31, even if paid in a lump sum on the last day of work.

6.4. Is a bona-fide severance package subject to salary conversion?

No, a bona-fide severance package would not be considered part of your regular pay, but rather a separate unemployment welfare benefit plan provided by the Employer. Once you terminate employment, you are no longer eligible to be a participant in the Plan; therefore any severance paid to you, that is, any pay made to you under the Employer's unemployment welfare benefit plan, may not take advantage of the pretax salary conversion feature of the Plan. However, if your Employer allows it, you may want to

make arrangements with the Plan Administrator to make Continuation Coverage payments from your severance pay.

6.5. What is the maximum Annual Benefit Limit?

The maximum Annual Benefit Limit is the maximum amount of Employer contributions available to any participant in the Plan which may be converted to Cafeteria Plan Dollars and must equal the total amount of the annual premiums anticipated for all benefits in the Plan.

The maximum amount of Cafeteria Plan Dollars which may be allocated to Insurance Premium Benefits is the cost of the premium rates from year to year of the most expensive benefits available to you in each Premium Benefit Program Option under the Plan. If the amount of the premium for insurance increases or decreases during the Plan Year, your Salary Conversion Election may be adjusted accordingly.

The maximum amount of Cafeteria Plan Dollars which may be allocated to Flexible Spending Arrangement benefits are limited as follows:

- Medical Expense Reimbursement Plan \$2,500

6.6. Can I change my elections during the Plan Year?

You may change or revoke your previous election at any time during the Plan Year and make a new election if there is one or more of the following Change in Status rules--

- your marriage or divorce;
- birth or adoption of your child;
- death of your spouse or child;
- a significant change in the medical benefits or premiums available either to you, through your employment with the Employer, or to your spouse, through his employer. If you otherwise are entitled to revoke an election or make an alternate election by reason of an increase in health insurance costs, you must do so within 30 days of receipt of written notice from the Plan Administrator of the significant change in cost or composition of the benefit originally elected; or
- termination of your employment, your spouse's employment, or change of either your or your spouse's employment status from full-time to part-time, or vice versa, or if either of you take an unpaid leave of absence from work.

If one of these qualifying Change in Status rules occurs, you must inform the Plan Administrator of your new election **within 30 days of the occurrence**. Failure to do so within the 30-day period will result in the changes in your election being applicable only to months during which, or after, you have notified the Plan Administrator.

6.7. Can I drop my election if I take a family or medical leave?

You may revoke any election you made for the period during which you are absent from work for a family medical leave covered by the federal Family and Medical Leave Act (FMLA). You may reinstate your election of group medical benefits when you return from the FMLA leave. However, you may not reinstate a revoked election as to any nonhealth insurance benefits until the next regular Enrollment Period.

PART III. ADMINISTRATION OF THE PLAN

VII. ADMINISTRATION OF ACCOUNTS

The Plan is administered by the Employer, which is the Plan Administrator and the fiduciary of the Plan for these purposes.

7.1. What are my “Cafeteria Plan Accounts”?

If you elect benefits under the Plan, one or more Cafeteria Plan Accounts (“Accounts”) will be set up in your name to keep a record of each benefit you are entitled to. How many accounts are established depends on which benefits you elect

7.2. How are my Accounts funded?

When you complete the enrollment form, you specify which benefits you wish to pay for through salary conversion. Thereafter, your accounts will be credited with that portion of your gross income you elect to forego through salary conversion. These portions will be credited as of each pay period. For example, suppose you elect the following:

| Benefit Elected | Annual Cost |
|------------------------------------|-----------------|
| Group Medical Insurance | \$ 750.00 |
| Medical Expense Reimbursement Plan | 1,000.00 |
| Dependent Care Assistance Plan | <u>2,000.00</u> |
| Total Annual Cost | \$3,750.00 |

Assuming you are paid semi-monthly, the cost of the above benefits per paycheck would be \$156.25. Your Accounts would be credited with a tax-free total of \$3,750.00, spread equally over 24 paychecks, or \$312.50 per month. Thus, each pay period, your accounts would be credited as follows:

| | |
|------------------------------------|--------------|
| Dependent Group Medical Insurance | \$31.25 |
| Medical Expense Reimbursement Plan | 41.67 |
| Dependent Care Assistance Plan | <u>83.33</u> |
| Total Credited per Pay Period | \$156.25 |

The total amounts that may be credited to your account during any one Plan Year will be limited to the Annual Benefit Limit in Answer 6.5. The amount that is available in any one of your Accounts at any particular time will depend on the benefits you elect. Premium benefit accounts are current in nature, and the Employer will pay out amounts you have set aside for insurance benefits as they become due to the insurance company or companies. If you elect Medical Expense Reimbursement benefits, your corresponding benefit Account will be credited to reflect the premiums you were paid, although the full, annual amount of the benefit will at all times be available to you (less previous benefits). If you choose to participate in the Dependent Care Assistance Plan, your corresponding benefit Account will be credited with the amount you set aside from each paycheck, and will accumulate until you submit a documented claim for reimbursement of eligible expenses.

7.3. Who holds the funds I have set aside under the Plan?

The money you set aside as payment for reimbursement of your Medical Expenses will be segregated by the Employer into a fund as soon as is administratively possible after an amount has been deducted from your paycheck.

7.4. Will my Accounts earn any interest?

No interest or other earnings will be credited to your Accounts at any time.

7.5. Will I have to pay any Plan administration fees?

No.

7.6. May I withdraw cash from any of my Accounts?

No. Your Account balances may be used only to provide premium payment or expense reimbursement benefits, as the case may be.

7.7. May I shift amounts from one Account to another?

No, you may *not* transfer credits from one Account to another. Thus, for example, credits to your Medical Expense Reimbursement Account may only be used for that type of expense; no amount would be available for any other purpose.

VIII. CLAIMS ADMINISTRATION

8.1. How do I receive my benefits under the Plan?

Generally, you will file a claim with the insurance company or third party hired by the Employer to handle your claims ("Claims Administrator") on claims forms that are provided for this purpose.

Flexible Spending Accounts. If Benefits are not provided through insurance, for example, vision care expenses or orthodontics work, you may apply to the Claims Administrator against your Flexible Spending Accounts when you believe you are entitled to payment, or you may use your debit card. (See 9.3 below) No benefit will be distributed from your Flexible Spending Accounts by the Claims Administrator until an application for benefit claim is filed. A written statement from an independent third party stating that the expense has been incurred and the amount of such expense must be submitted. Claims applications must be filed within 90 days after the end of the Plan Year for expenses incurred during the prior Plan Year.

If you elected to participate in the Medical Expense Reimbursement Plan and you did not use your debit card, you will have to take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment out of one of your Accounts, you submit a claim to the Claims Administrator on a claim form which is found at the JEM Website. See Section IV of this Summary for a description of the reimbursement procedures that apply to Medical Expenses. You may not be reimbursed for any expenses with respect to the current year of your participation that incurs before the Plan becomes effective, before your enrollment form becomes effective, or for any expenses incurred after the close of the Plan Year.

Review the list of eligible expenses included with the Claim Form for assistance in determining what is an "eligible expense," as well as the list provided on the JEM Website under "*Section 125 Cafeteria Plan Booklet.*" You are also encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

8.2. When do I submit my claims?

You may submit your claims at any time by mail or by fax to the Claims Administrator to the address or fax number on the Claim Form. Generally, claims and checks are processed twice a week. In addition, you will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement for eligible expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

8.3. How does the debit card work?

Your Employer provides a unique claims process which cuts down on most paper claim forms by utilizing the JEM debit card system. You may use your debit card to pay for your out-of-pocket medical and dependent care expenses at the time of service. In general, the debit card works like an ATM card by

automatically debiting your MERP or DCAP Account and transferring your pre-tax dollars to the provider to pay your expenses. However, just like any other form of debit card, the provider has to be set up to use the JEM debit card system and must follow certain guidelines for providing a claims "paper trail." This keeps you from having to turn in any claims paperwork. However, you should always keep copies of all your debit card claims receipts in case there is any need for proof of claims from the Claims Administrator. The Claims Administrator has the right to request claims receipts at any time. Should you fail to produce these receipts, your debit card may be inactivated or revoked.

Only eligible expenses may be debited from your Account. The provider must use expense codes which are set up in the debit card system. If the wrong expense code is entered (for example, unqualified over the counter drugs at the pharmacy, or cosmetic procedures at your dermatologist), your attempt to use your debit card for this expense will be denied. You should refer to the Claims Administrator's "*Section 125 Cafeteria Plan Booklet*" at the JEM Website for a list of qualified expenses before using your debit card.

Additionally, your expense cannot be for more than the amount funded to your MERP or DCAP Account. For example, if you try to pay a \$100 hospital co-pay at the end of the Plan Year, and you only have \$89 left in your MERP Account, your debit card will deny the entire \$100 claim. In this example, your provider should enter \$89 as your co-pay (minus any per transaction fee that may be applicable) and you will have to pay the remainder out-of-pocket, or you can file a manual claim.

The claims administration rules in this Section IX will apply to debit cards where applicable.

8.4. Will unused year-end Account balances be carried over to the next Plan Year?

No. Any amounts remaining in your Cafeteria Plan Account at the end of a Plan Year which are not used to purchase Benefits or reimburse expenses incurred during the Plan Year will be forfeited per IRS regulations. You will have 90 days after the Plan Year ends to submit claims for reimbursement.

8.5. Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not currently taxable to you under present law. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

8.6. What happens if my claim for benefits is denied?

You will be notified in writing by the Claims Administrator within 60 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. The notification will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

IX. PLAN AMENDMENT AND TERMINATION

9.1. How long will the Plan remain in effect?

The Employer intends that the Plan will be a permanent program to benefit Employees. However, the Employer reserves the right to amend or terminate the Plan at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly. Any such amendment or termination may be complete or partial and may be made retroactive to the extent allowed by law, but neither action will deprive you of any benefits to which you have previously become entitled. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs.

9.2 What is a Summary of Material Modifications?

Periodically, you may receive a copy of a Summary of Material Modifications (SMM). Like this Summary Plan Description, a Summary of Material Modifications summarizes the effect of any amendments made to the Plan. You should keep any SMMs you receive as "amendments" to this Summary Plan Description.

X. QUALIFICATION OF PLAN AND RELATED MATTERS

The Plan is intended to be a "cafeteria plan" under Section 125 of the Internal Revenue Code and the description of the Plan in this summary is based on the assumption that the Plan does so qualify. However, neither the Employer, the Plan Administrator, nor any other agent of the Employer or the Plan represents or guarantees that the Plan will be so qualified at any time, nor is the Employer obligated to amend any aspect of the Plan which results in failure to meet the requirements of the Internal Revenue Code. The failure of the Plan to qualify under the Code could result in significant and adverse tax consequences to Participants in the Plan. For each Plan Year, you may elect to convert a portion of your Compensation to "Cafeteria Plan Dollars." Your taxable Compensation will be reduced to the extent of your election. Only Cafeteria Plan Dollars may be used to purchase Benefits available under the Plan.

The Plan Administrator will provide an enrollment and election form to each Employee who is eligible to participate in the Plan. Your election will not be effective unless your form is returned to the Plan Administrator prior to the close of the Open Enrollment Period which precedes your elections beginning under the Plan. Your election will continue until you change or discontinue it or become ineligible to participate in the Plan.