GREAT NECK UNION FREE SCHOOL DISTRICT'S
FLEXIBLE BENEFITS PLAN

Amendment and Restatement
Effective as of July 1, 2003
(With Health and Dependent Care Flexible Spending Accounts
Component Plans Effective January 1, 2004)

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TABLE OF CONTENTS

ARTICLE 1
DEFINITIONS

ARTICLE 2
PARTICIPATION

ARTICLE 3
ELECTION OF BENEFITS

ARTICLE 4
PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS

ARTICLE 5
CREDITS AND DEBITS TO ACCOUNTS

ARTICLE 6
BENEFITS

ARTICLE 7
HEALTH INFORMATION PRIVACY

ARTICLE 8
ADMINISTRATION

ARTICLE 9
CLAIMS PROCEDURE

ARTICLE 10
AMENDMENT OR TERMINATION OF PLAN

ARTICLE 11
GENERAL PROVISIONS

GREAT NECK UNION FREE SCHOOL DISTRICT'S FLEXIBLE BENEFITS PLAN

Amendment and Restatement
Effective as of July 1, 2003
(With Health and Dependent Care Flexible Spending Account Component Plans Effective January 1, 2004)

PREAMBLE

This amendment and restatement of the Great Neck Union Free School District's Flexible Benefits Plan (the "Plan") is generally effective as of July 1, 2003. Notwithstanding the preceding, the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account provisions of the Plan are first effective as of January 1, 2004. In addition, to the extent necessary in order for the Plan to comply with the Privacy Regulations described in Article 7, Article 7 of the Plan is effective as of April 14, 2003.

The purpose of the Plan is to allow eligible employees of the Employer to choose benefits from among those benefits provided under the Plan.

The Plan is intended to be a "cafeteria plan" meeting the requirements of '125 of the Internal Revenue Code of 1986, as amended.

ARTICLE 1
DEFINITIONS

The following terms, when used herein, shall have the meanings indicated, unless the context clearly requires otherwise:

1.1 ADMINISTRATOR means the Plan Administrator referred to in Article 8.

1.2 BENEFIT ACCOUNT is defined in Section 4.1.

1.3 BENEFIT CREDITS means the benefit credits, if any, allocable to a Participant in any Plan Year, as determined by the Employer, and communicated to Participants from time to time.

1.4 BENEFITS means those benefits or coverages available for election by a Participant under Article 6.

1.5 CODE means the Internal Revenue Code of 1986, as amended, and shall be deemed to include the regulations issued thereunder.

1.6 COMPONENT PLAN means any plan or program referred to in Article 6 and any other plan or program designated by the District as a Component Plan.

1.7 DEPENDENTS means the following individuals with respect to a Participant:

(a) the spouse of a Plan Participant;

(b) an unmarried child of a Plan Participant if such child is under age nineteen (19) and who receives over half of his or her support from the Participant;

(c) an unmarried child of a Plan Participant if such child is age nineteen (19) or over, but under age twenty-five (25), a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and who receives over half of his or her support from the Participant;

(d) any child of a Plan Participant who is mentally or physically incapable of self-support and who receives over one-half of his or her support from the Participant, regardless of the age of such child, provided such mental or physical condition commenced prior to the attainment by the child of age nineteen (19), or age twenty-five (25) if the child was enrolled as a full-time student at the date of such commencement;

(e) any child of a Participant who does not qualify as a dependent under Sections 1.7(b), 1.7(c) or 1.7(d) above, solely because the child is not primarily dependent upon the Participant for support so long as over half of the support of the child is treated as having been received by the child from the Participant pursuant to a multiple support agreement as described in '152(c) of the Code;

(f) Any other individual who is a dependent of the Participant described in '152(a) of the Code and whose welfare is the legal responsibility of the Plan Participant pursuant to a written divorce settlement, written separation agreement, court order or order by an administrative process having the force and effect of state law.

For purposes of the preceding paragraph, the word "child" includes natural children, legally adopted children who are under age eighteen (18) years of age at the time of the adoption, foster children (provided the foster child is not a ward of the state), stepchildren and children placed for adoption who are under eighteen (18) years of age at the time of the placement who depend on the Participant for support.

In addition, a spouse or child will not qualify as an eligible dependent if such spouse or child is on active duty in the armed forces of any country or if such spouse or child is an Employee of the Employer. Finally, a person otherwise qualifying as an eligible dependent will not be covered for any coverage providing benefits to dependents unless the Participant has elected to pay and has paid the required additional contributions, if any, for dependent coverage.

1.8 DISTRICT means the Great Neck Union Free School District and any successor entity.

1.9 EFFECTIVE DATE means July 1, 2003 with respect to all Component Plans other than the Health Care Flexible Spending Account Component Plan and the Dependent Care Flexible Spending Account Component Plan. With respect to the Health Care Flexible Spending Account Component Plan and the Dependent Care Flexible Spending Account Component Plan, "Effective Date" means January 1, 2004. In addition, to the extent necessary in order for the

Plan to comply with the Privacy Regulations described in Article 7, Article 7 of the Plan is effective as of April 14, 2003.

1.10 ELECTION FORM means the form provided by or process designated by the Administrator by which an Employee or a Participant enrolls or re-enrolls in the Plan and elects Benefits in accordance with Article 3.

1.11 EMPLOYEE means a person who is a regular contractual employee of the Employer (as determined by the Employer). Notwithstanding the foregoing, the term Employee shall not include (a) any person who is not classified by the Employer as a common law employee of the Employer for the period during which the person is not so classified by the Employer notwithstanding the later reclassification by a court or any regulatory agency of the person as a common law employee of the Employer or (b) any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).

1.12 EMPLOYER means the District and any other entity which, with the consent of the Board of the District, adopts the Plan by action of its Board.

1.13 INSURER means any insurance company to which premiums are paid and which provides benefits with respect to a Participant in accordance with Article 6.

1.14 PARTICIPANT means an Employee who becomes a Participant pursuant to Article 2.

1.15 PARTICIPANT ACCOUNT is defined in Section 4.1.

1.16 PARTICIPATION DATE is the first date as of which an Employee may participate in the Plan (or a particular Component Plan, if applicable), as set forth in Section 2.1.

1.17 PLAN means, collectively, the Great Neck Union Free School District's Flexible Benefits Plan as herein set forth and as it hereafter may be amended from time to time and the Component Plans hereunder.

1.18 PLAN YEAR means, effective as of July 1, 2003, the twelve (12) consecutive month period beginning each January 1 and ending each December 31 during which this Plan is in effect. Prior to July 1, 2003, Plan Year meant the twelve (12) consecutive month period beginning each July 1 and ending each June 30 during which this Plan is in effect. The Plan shall experience a short Plan Year beginning July 1, 2003 and ending December 31, 2003.

1.19 RECORDKEEPER means an outside entity which the Administrator may contract to provide certain recordkeeping, claims processing and other administrative services on their behalf.

1.20 SPECIAL ENROLLMENT PERIOD means a period, other than an "initial enrollment period" or an "open enrollment period", as provided in Section 3.5, during which an Employee or Dependent may enroll in the Plan.

1.21 STATUS CHANGE means, and is limited to:

(a) an event that changes an Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(b) an event that changes an Employee' number of Dependents, including the birth, adoption, placement for adoption (as defined in regulations under Code '9801) or death of a Dependent;

(c) an event that changes the employment status of an Employee or the Employee's Dependent including the termination or commencement of employment by the Employee or the Employee's Dependent, the change in worksite of the Employee or the Employee's Dependent, the reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence) of the Employee or the Employee's Dependent and any change in the employment status of an Employee or the Employee's Dependent that results in that person becoming (or ceasing to be) eligible under a plan sponsored by that person's employer;

(d) an event that causes the Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the Component Plan(s) under which the Employee is covered;

(e) the change in location of the residence of the Employee or the Employee's Dependent;

(f) for purposes of a Component Plan offering dependent care assistance benefits, an event that changes the number of Qualifying Individuals, as defined in Section 6.1(d)(v).

1.22 WAIVER DATE means the later of (i) an Employee's Participation Date if the Employee waives coverage under a Component Plan described in Section 3.5(c), as of such date for the Employee or an eligible Dependent or (ii) an "open enrollment period" prior to the Special Enrollment Period for an Employee under Section 3.5(c) during which, in the case of a Special Enrollment Period for an Employee, the Employee failed to elect coverage under the Component Plan described in Section 3.5(c), for the Employee or, in the case of a Special Enrollment Period for a Dependent, the Employee failed to elect coverage for the Dependent; provided, however, that the Employee or the Dependent, as applicable, has not received coverage under the Component Plan described in Section 3.5(c) during the period beginning with such "open enrollment period" and ending with such Special Enrollment Period.

ARTICLE 2
PARTICIPATION

2.1 PARTICIPATION. Each Employee is eligible to participate in the Plan (other than the Flexible Spending Account features of the Plan) as of the later of the Effective Date or his or her "Participation Date," which, with respect to Employees hired during July and August to begin active employment in September, will be the September 1st following the Employee's date of hire and which, with respect to all other Employees, will be the first day of active employment. Each Employee is eligible to participate in the Flexible Spending Account features of the Plan as of the later of January 1, 2004 or the first day of the calendar year next following the date the Employee becomes an Employee (the Employee's "Participation Date" with respect

to the Flexible Spending Account features of the Plan). However, individual Component Plans may impose certain eligibility and participation requirements as provided therein.

Each Employee shall become a Participant on his or her "Participation Date", provided that the Employee completes and submits an Election Form on or prior to that date and provided further that the Employee has the status, as determined by the Employer, of an active Employee of the Employer on such date. If an Employee does not become a Participant on his or her "Participation Date", the Employee shall become a Participant on the first day of a Plan Year following his or her completion or submission of an Election Form or, if applicable, the date of coverage resulting from Status Change as provided herein or the date of coverage resulting from an Employee's election during the Employee's Special Enrollment Period, as provided in Section 3.5; provided, however, that, except in the case of Component Plans providing medical coverage, any Employee who does not become a Participant on the earliest possible date under the Plan, and/or such Employee's Dependents, may be required by the Employer, at their own expense, to submit such proof of good health as the Employer, in its discretion, may require prior to the Participant's or Dependent's, as applicable, commencement of participation in the Plan. The Dependents of a Participant are eligible for benefits under the Plan through and only through the Participant.

For purposes of the Plan's requirement that an Employee be an active Employee on his or her Participation Date to become a Participant, an Employee who is absent from work on his or her Participation Date because of a health condition, will be treated as an active Employee on that date.

2.2 TERMINATION OF PARTICIPATION. A Participant's participation in the Plan shall terminate on the earliest of the following dates:

(a) The day on which the Participant terminates employment.

(b) The day on which the Participant ceases to qualify as an Employee or a Participant.

(c) With respect to any coverage requiring Participant contributions and with respect to which Participant contributions are discontinued, the last day of the period for which contributions by the Participant are paid.

(d) The day on which the Participant reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

A Dependent's participation in the Plan shall terminate on the earliest of the following dates:

(a) The day on which the Participant terminates employment.

(b) The day on which the Participant ceases to qualify as an Employee or a Participant.

(c) With respect to any coverage requiring Participant contributions and with respect to which Participant contributions are discontinued, the last day of the period for which contributions by the Participant are paid.

(d) The day on which the Dependent reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan, by exclusion of the applicable benefit(s), or all benefits, as to Dependents, or by discontinuation of contributions by the Employer.

(f) The day on which the Dependent ceases to be a Dependent.

Notwithstanding the preceding, if a Participant takes a leave of absence from employment with the Employer by reason of "service in the uniformed services" as defined in section 4303(b)(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), such Participant may elect to continue to participate in the Plan to the extent required by USERRA with respect to the Participant and his or her Dependent(s), if any. Such a Participant shall be required to pay for such coverage in an amount as determined under USERRA section 4317(a)(1)(B). The coverage of any such Participant and his or her Dependent(s), if any, shall end upon the earlier of: (1) the last day of the eighteen (18) month period beginning on the date on which the Participant's absence begins; or (2) the day after the date on which the Participant fails to apply for or return to a position of employment with the Employer as determined under USERRA section 4312(e).

2.3 REHIRED EMPLOYEES. For purposes of Section 2.1, if a former Participant once again becomes an Employee, his or her Participation Date is the date he or she again becomes an Employee. However, if such a former Participant again becomes an Employee during the same Plan Year as occurred his or her prior cessation of participation in this Plan, he or she may not make a new Code '125 pre-tax salary reduction election until the election period for the next following Plan Year unless permitted under Section 3.5.

ARTICLE 3
ELECTION OF BENEFITS

3.1 ELECTION OF BENEFITS: IN GENERAL. An Employee may elect, on his or her Election Form and in accordance with the following provisions of this Article, any one or more of the Benefits available under Article 6.

3.2 ELECTION FORM: CONTENTS. An Employee's Election Form shall contain such information as the Administrator may deem appropriate.

3.3 ELECTION FORM: INITIAL ELECTION PERIOD.

(a) Medical/Prescription Drug Component Plan. An Employee who becomes eligible to become a Participant in the medical/prescription drug Component Plan must complete, sign and file an initial Election Form with the Administrator during the period preceding his or her Participation Date (as defined in Section 2.1) that is identified by the Administrator as the Employee's initial "enrollment period" in order to enroll in the medical/prescription drug Component Plan during his or her initial coverage period. Such an Employee's initial coverage period with respect to the medical/prescription drug Component Plan is the period beginning on his or her Participation Date and ending on the last day of the Plan Year in which falls the Participation Date. The medical/prescription drug elections made by the Employee on this initial Election Form shall be effective, subject to Section 3.5, for the period beginning on the Participant's Participation Date and ending on the last day of the Plan Year during which the Participant changes his or her initial elections pursuant to Section 3.4.

(b) All Other Component Plans. An Employee who becomes eligible to become a Participant in any Component Plan other than the medical/prescription drug Component Plan must complete, sign and file an initial Election Form with the Administrator during the period preceding his or her Participation Date (as defined in Section 2.1) that is identified by the Administrator as the Employee's initial "enrollment period" in order to enroll in such Component Plan during his or her initial coverage period. The non-medical/prescription drug elections made by the Employee on this initial Election Form shall be effective, subject to Section 3.5, for the period beginning on his or her Participation Date and ending on the last day of the Plan Year in which falls the Participation Date (which period shall be deemed to be such Employee's initial coverage period).

(c) Employees Who Fail to File an Initial Election Form. An eligible Employee who fails to complete, sign and file an Election Form with the Administrator in accordance with Section 3.3(a) or 3.3(b) above prior to his or her initial coverage period will not participate automatically in any portion of the Plan. Such an Employee may become a Participant on a later date in accordance with Sections 3.4 or 3.5.

3.4 ELECTION FORM: ANNUAL ELECTION PERIODS AFTER INITIAL ELECTION PERIOD. A Participant's initial medical/prescription drug coverage elections shall continue indefinitely, subject to Section 3.5. Notwithstanding the preceding, a Participant may change his or her initial medical/prescription drug coverage elections for any subsequent Plan Year by requesting, completing and submitting a new Election Form for the applicable Plan Year for which such Election Form is to become effective during the period preceding such applicable Plan Year that is identified by the Administrator as the Plan's annual "election period". The medical/prescription drug coverage elections made by the Participant on each such Election Form shall be effective, subject to Section 3.5, beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this Section.

With respect to non-medical/prescription drug coverage elections, after completing and submitting an initial Election Form, each Participant shall, subject to any restrictions on changing coverage or coverage levels imposed by the Administrator or the Component Plans, complete and submit a new Election Form for each new Plan Year for which such Election Form is to become effective, such completion and submission to be accomplished during such period preceding such applicable Plan Year that is identified by the Administrator as

the Plan's annual "election period". The elections made by the Participant on each such Election Form shall be effective, subject to Section 3.5, for the next following Plan Year.

Notwithstanding the preceding, with respect to any Component Plan under which the Employee becomes ineligible following the completion of an Election Form with respect to such Component Plan, the election made by the Participant on each such Election Form shall not remain in effect beyond the date on which the Employee becomes ineligible. If an Employee who is a Participant fails to complete and submit an Election Form during the Plan's annual "election period", the Employee shall be deemed to have elected the same medical/prescription drug Benefits and coverages then in effect for such Participant, at the cost determined by the Employer. If an Employee who is a Participant fails to complete and submit an Election Form as required by this Section, the Employee shall not participate in the non-medical/prescription drug provisions of the Plan for the period of coverage which is the subject of the Election Form unless such participation is pursuant to Section 3.5.

3.5 CHANGES OF ELECTION TO REFLECT STATUS CHANGE OR TO REFLECT THE EXERCISE OF SPECIAL ENROLLMENT RIGHTS; OTHER ELECTION CHANGES.

(a) Status Change Rules. Within thirty (30) days after the occurrence of a Status Change, a Participant may, with the approval of and pursuant to guidelines established by the Administrator, change his or her election of Benefits hereunder, and any salary reduction agreement referenced in Section 5.2, in a manner which is Consistent (as defined in Section 3.5(b)) with the Status Change.

With the approval of and pursuant to guidelines established by the Administrator, an Employee who is eligible to become a Participant but has failed to complete an Election Form may become a Participant and file an Election Form within thirty (30) days after a Status Change occurs, provided that the Employee's commencement of participation and election of Benefits with respect thereto is Consistent (as defined in Section 3.5(b)) with the Status Change.

Elections made pursuant to this Section shall take effect as soon as practicable after the date the eligible Employee has properly filed his or her Election Form and such election has been approved by the Administrator (or on such other date specified by the Administrator), and shall remain in effect until the earlier of (i) in the case of medical/prescription drug coverage elections, the end of the Plan Year in which the Participant makes an election pursuant to Section 3.4 and, in the case of elections relating to non-medical/prescription drug coverage, the end of the Plan Year in which the election is made, (ii) the date on which the Employee becomes ineligible for coverage under any Component Plan, or (iii) the date the Employee again changes his or her election because of a subsequent Status Change. Except for a change permitted under Section 3.5(c)(ii) because of a birth, adoption or placement for adoption, any change permitted by this Section 3.5 to an Employee's salary reduction agreement under Section 5.2 may be made on a prospective basis only and may not be used to fund costs of coverage provided before the effective date of such a change.

(b) "Consistent" Defined. Except as otherwise provided in this Section 3.5(b), an election change is "Consistent" with a Status Change only if the election change is on account of and corresponds with a Status Change that affects the Employee's or the Employee's

Dependent's eligibility for coverage under an employer's plan. An election change to decrease or cancel coverage under a Component Plan is not Consistent with a Status Change because of an Employee or a Dependent becoming eligible for coverage under an employer's plan unless the Employee or Dependent actually elects such coverage. In determining whether an election change is Consistent for purposes of the preceding sentence, the Employer may rely on the Employee's certification that alternative coverage has been or will be obtained, unless the Employer has reason to question the accuracy of that certification.

An election change with respect to a Component Plan offering dependent care assistance benefits is also Consistent with a Status Change if the election change is on account of and corresponds with a Status Change that affects expenses covered under that Component Plan.

(c) Rules Applicable to the Exercise of Special Enrollment Rights. The following provisions take precedence over any conflicting provision of this Plan. For purposes of this Section 3.5(c) only, the term "Plan" refers to coverage only under the Component Plan(s) that offer medical benefits.

(i) Special Enrollment Rights of Employees and Dependents Who Lose Alternative Coverage after Becoming Eligible to Be Covered under the Plan. If (A) an Employee fails to enroll in the Plan as of his or her Waiver Date (and/or if an Employee fails to enroll his or her Dependent(s) in the Plan as of the Employee's Waiver Date with respect to such Dependent(s)), (B) the Employee (and/or, in the case of a Dependent, the Dependent) is covered under another group health plan or had other health insurance coverage on the Employee's Waiver Date and (C) if required by the Administrator, the Employee provides to the Administrator on or prior to the Employee's Waiver Date, on a form provided by the Administrator, notice that such alternative coverage was the reason the Employee declined coverage for the Employee and/or the Employee's Dependent(s), as applicable, then the Employee and/or Dependent(s), as applicable, shall be permitted to become enrolled in the Plan, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Employee's and/or Dependent's Special Enrollment Period without regard to Sections 2.1, 3.3 or 3.4 and without regard to whether a Status Change has occurred. The Special Enrollment Period under this Section 3.5(c)(i), shall be the period ending thirty (30) days after the termination of the alternative coverage.

The foregoing Special Enrollment Period rights apply only to terminations of coverage resulting, (A) in the case of alternative coverage received by the Employee or Dependent under COBRA, (I) for a reason other than failure of the Employee or Dependent to pay for the coverage on a timely basis or other than for cause (including, but not limited to, making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the coverage), or (II) due to the Employee or Dependent, as applicable, no longer residing, living or working in a service area of an HMO or similar program that was the alternative coverage at a time when there is no other COBRA continuation coverage available to the Employee or Dependent or, (B) in the case of an alternative coverage other than COBRA coverage, (I) the coverage has been terminated as a result of loss of eligibility for the coverage because of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment (or after a period measured with reference to any of the foregoing) or (II) the coverage has been terminated because employer contributions, if applicable, toward the alternative coverage have been terminated.

In the case of an election by an Employee under this Section 3.5(c)(i), the Employee's or Dependent's coverage shall become effective on the first day of the month next following the later of the termination of the alternative coverage or the Administrator's receipt of an Election Form submitted during the Special Enrollment Period electing coverage for the Employee and/or Dependent(s) under the Plan. The elections on such Election Form shall remain effective as if made on the first day of the Plan Year that includes the date coverage begins under this Section, but shall be first effective only as provided in the preceding sentence.

The foregoing Special Enrollment Period rights are available to an enrolling Employee and his or her enrolling Dependent(s) if the enrolling Employee and enrolling Dependent(s) did not become enrolled in the Plan as of the Employee's Waiver Date and, when enrollment in the Plan was declined as of the Employee's Waiver Date, the Employee or the Dependent(s) was covered under the alternative coverage; provided, however, that enrollment of a Dependent in accordance with the foregoing provisions under circumstances where the Employee is not enrolled in the Plan shall be permitted only if the Employer makes available Dependent-only coverage under the Plan. The foregoing Special Enrollment Period rights are available to the enrolling Employee if the enrolling Employee failed to begin participation on his or her Waiver Date and, when enrollment in the Plan was declined by the enrolling Employee, the enrolling Employee was covered under the alternative coverage. The foregoing Special Enrollment Period rights are available to an enrolling Dependent if the Dependent is a Dependent of an active Participant and, when coverage of the Dependent was offered to the Participant and was declined, the Dependent was covered under the alternative coverage.

(ii) Special Enrollment Rights of Employees and Dependents in the Case of Marriage, Birth, Adoption or Placement for Adoption. In the case of the marriage of an Employee, the birth of a child of the Employee, or the adoption by or placement for adoption of a child with the Employee, the Employee and/or the Employee's Dependent(s), as applicable, shall be entitled to enroll in the Plan during a Special Enrollment Period, as follows:

(A) An Employee is entitled to elect enrollment for the Employee under the Plan, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period if an individual becomes a Dependent of the Employee through marriage, birth, or adoption or placement for adoption.

(B) An active Participant may enroll in the Plan an individual who becomes or is a spouse of the Participant, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period if either (I) the individual becomes a spouse of the Participant or (II) the individual is a spouse of the Participant and a child becomes a Dependent of the Participant through birth, or adoption or placement for adoption.

(C) An Employee may elect to enroll in the Plan the Employee and an individual who is or becomes a spouse of the Employee, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period if the Employee failed to enroll in the Plan as of the Employee's Waiver Date and either (I) the Employee and the individual become married or (II) the Employee and the

individual already are married and a child becomes a Dependent of the Employee through birth, or adoption or placement for adoption.

(D) An active Participant may enroll a Dependent in the Plan, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period if the Dependent becomes a Dependent of the Participant through marriage, birth, or adoption or placement for adoption.

(E) An Employee may elect to enroll the Employee and the Employee's Dependent (whether or not that Dependent is a spouse of the Employee) in the Plan, and make a corresponding change in his or her salary reduction agreement under Section 5.2, if any, during the Special Enrollment Period if the Employee failed to elect coverage under the Plan as of the Employee's Participation Date and the Dependent becomes a Dependent of the Employee through marriage, birth, or adoption or placement for adoption.

The Special Enrollment Period under this Section 3.5(c)(ii), shall begin on the date of the marriage, birth, or adoption or placement for adoption that gives rise to the Special Enrollment Period (or, if later, the Participant's Participation Date) and shall end thirty (30) days after such date. In the case of an election by an Employee and/or Dependent for coverage under the Plan during a Special Enrollment Period, such coverage shall be effective, (A) in the case of a marriage, on a date specified by the Administrator that is not later than the first day of the first month beginning after the date the Employee submits to the Administrator an Election Form electing coverage for the Employee and/or Dependent(s) under the Plan, (B) in the case of a Dependent's birth, the date of such birth, and, (C) in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. The elections on such Election Form shall remain effective as if made on the first day of the Plan Year that includes the date coverage begins under this Section, but shall be first effective only as provided in the preceding sentence.

(d) Significant Changes in Cost or Coverage. Any election change permitted under this Section 3.5(d) must be requested, pursuant to procedures established by the Administrator, within a reasonable time after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

(i) Significant Cost Changes. If the cost payable by an Employee for coverage offered under a Benefit option significantly changes during a Plan Year, as determined by the Employer, the Employee may make corresponding changes to his or her election of Benefits and to his or her salary reduction agreement under Section 5.2. If the change is an increase in the Employee's cost of that coverage, an Employee who is a Participant may elect to replace his or her coverage with coverage available under another Benefit option, if any, that offers similar coverage, as determined by the Employer, or, if no other similar Benefit option is available, a Participant may drop the coverage. If the change is a decrease in the Employee's cost of coverage under a Benefit option, a Participant or an Employee who is eligible to become a Participant may elect that coverage.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Employee's cost for a Benefit option regardless of whether the increase or decrease results from an action taken by the Employee or from an action taken by the Employer.

Notwithstanding anything else in this Section 3.5(d)(i), for any change in costs associated with a Dependent Care Flexible Spending Account or any other Component Plan that is a dependent care assistance program described in '129 of the Code, an Employee may not change his or her salary reduction agreement or election of Benefits if the cost change is imposed by a dependent care provider who, with respect to the Employee, is a parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

(ii) Coverage Changes.

(A) Curtailment Without Loss of Coverage. If a Participant or a Participant's Dependent experiences a significant curtailment of coverage under a Benefit option that is not a loss of coverage (as defined in applicable law), as determined by the Employer, the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to his or her salary reduction agreement under Section 5.2. Coverage under a Benefit option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by the Employer.

(B) Loss of Coverage. If a Participant or a Participant's Dependent experiences a significant curtailment of coverage under a Benefit option that is a loss of coverage (as defined in applicable law and as determined by the Employer), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to his or her salary reduction agreement under Section 5.2. If no similar coverage is available to replace the Benefit option for which a loss of coverage occurred, a Participant may elect to drop the coverage.

For purposes of this Section 3.5(d)(ii), Aloss of coverage" means a complete loss of coverage under a Benefit option and includes, for example, the elimination of a Benefit option, the loss of availability of an HMO option in the area where the Participant or Dependent resides, a Participant's or Dependent's loss of coverage under a health plan option because expenses exceed an annual or lifetime limit and other similar events, as determined by the Employer. In addition, the Employer, in its discretion, may elect to treat as a loss of coverage any of the following: (1) a substantial decrease in the medical care providers available under the Benefit option; (2) with regard to a specific Participant or Dependent, a reduction in benefits provided under a health plan for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or (3) any similar fundamental loss of coverage.

(C) Addition of Option. If the Employer adds a new Benefit option or if coverage under an existing Benefit option is significantly improved during a Plan Year, as determined by the Employer, a Participant who elected a Benefit option for the Plan Year that provides similar coverage, as determined by the Employer, may change his or her election of Benefits to replace that Benefit option with the new or improved Benefit option and may make corresponding changes to his or her salary reduction agreement under Section 5.2, if

applicable. Any Participant, or any Employee who is eligible to become a Participant, who did not elect any Benefit option for the Plan Year that provides coverage similar to that offered under a new or improved Benefit option, as determined by the Employer, may change his or her election of Benefits to elect the new or improved Benefit option and may make corresponding changes to his or her salary reduction agreement under Section 5.2, if applicable.

(iii) Changes Under Another Employer's Plan. A Participant, or an Employee who is eligible to become a Participant, may change his or her election of Benefits and salary reduction agreement under Section 5.2 on account of and corresponding to (A) an election change made during a period of coverage by a Dependent or a former spouse under a plan sponsored by that person's employer, if the change is one that is permitted under that

employer's plan under provisions similar to the provisions in this Section 3.5, or (B) an election change made by a Dependent or a former spouse under a plan sponsored by that person's employer that corresponds to a period of coverage that is different from the Plan Year.

(iv) Loss of Other Group Health Coverage. If a Participant, or an Employee who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Employee may change his or her election of Benefits and salary reduction agreement under Section 5.2 to elect coverage for the affected individual.

Nothing in this Section 3.5(d) shall be construed to permit a change to an Employee's election of Benefits or salary reduction agreement under Section 5.2 with respect to a Health Care Flexible Spending Account or to permit a change of election with respect to any Component Plan because of cost or coverage changes associated with a health care flexible spending account sponsored by the Employer or by a Dependent's Employer.

(e) Other Election Changes. Any election change permitted under this Section 3.5(e) must be requested, pursuant to procedures established by the Administrator, within a reasonable time after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

(i) Judgment, Decree or Order. If an Employee is subject to a judgment, decree or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident and/or health coverage for the Employee's child, the Employee, or if required by the Order, the Employer or the Administrator, may change the Employee's election of Benefits and salary reduction agreement under Section 5.2, if any, to provide coverage for the child if the Order requires coverage under the Plan. If the Order requires the Employee's spouse, former spouse or another individual to provide coverage for the child, the Employee may change his or her election of Benefits and salary reduction agreement under Section 5.2, if any, to cancel coverage for the child, if the Employee provides adequate proof, as determined by the Employer, that the coverage required by the Order is actually being provided.

(ii) Medicare/Medicaid Eligibility. If a Participant or a Participant's Dependent who is enrolled in a Component Plan that offers accident and/or health coverage, becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make an election change to cancel or reduce coverage of that Participant, or his or her Dependent, under the Component Plan that offers accident and/or health coverage, and may change his or her salary reduction agreement under Section 5.2 accordingly. If an Employee or an Employee's Dependent, who was previously enrolled under Medicare or Medicaid as described in the previous sentence (other than coverage under section 1928 of the Social Security Act), loses eligibility for such coverage, the Employee may elect coverage for that individual under a Component Plan that offers accident and/or health coverage.

(iii) Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act of 1993 ("FMLA") may revoke an existing election of group health coverage and, upon return from FMLA leave, may make other elections concerning group health coverage that are permitted by FMLA. A Participant may make corresponding changes to

his or her salary reduction agreement under Section 5.2 to reflect these special FMLA-permitted changes.

ARTICLE 4
PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS

4.1 PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS. The Recordkeeper shall maintain records reflecting a Participant Account for each Participant. The Participant Account shall be divided into sub-accounts (hereinafter referred to as "Benefit Accounts") for each Benefit elected by the Participant.

4.2 CREDITING AND ALLOCATING ACCOUNTS. Amounts shall be credited to Participant Accounts in accordance with Sections 5.1 and 5.2, and allocated to Benefit Accounts in accordance with Section 5.3.

4.3 DEBITING OF ACCOUNTS. Benefit Accounts shall be debited in accordance with Section 5.3.

4.4 ACCOUNTS AS BOOK ENTRIES ONLY. Participant Accounts and Benefit Accounts shall be maintained by the Recordkeeper as entries on its books.

No money shall actually be paid into any Participant Account or Benefit Account. No assets or funds shall be paid to, held in or invested in any separate trust.

No interest will be credited to or paid on amounts credited to any Participant Account or Benefit Account.

ARTICLE 5
CREDITS AND DEBITS TO ACCOUNTS

5.1 BENEFIT CREDITS. As of the first day of each period, as designated by the Employer and following a Participant's Participation Date, the Participant Account of that Participant on such date shall be credited with an amount equal to the appropriate Benefit Credits, if any (as determined by the Employer), allocable to such Participant for that period.

5.2 SALARY REDUCTION CONTRIBUTIONS. During the applicable election period determined under Article III, a Participant may enter into a salary reduction agreement with the Employer which directs that the Participant's salary for the period to which the election relates shall be reduced each payroll period and that the amount of such reduction will be credited to the Participant's Participant Account.

The elected salary reduction, as applicable to any Participant, is subject to reduction by the Administrator to the extent deemed necessary by the Administrator to avoid the Plan being discriminatory as defined in the Code.

The elected salary reduction, as applicable to any Participant's health coverage election, is subject at all times to the Employer's right to increase the elected salary reduction if the Employer determines that there is empirical evidence of a significant increase in the cost of coverage under the Plan's health benefit provisions or if the cost of health benefit coverage under the Plan increases as a result of actions by an independent, third-party provider.

5.3 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS. Amounts credited to a Participant's Participant Account shall be allocated, on the date credited, to the Benefit Accounts of the Participant. Such allocation shall be made pursuant to the election made by the Participant in accordance with Section 6.1. However, in no event may an amount in excess of the total amount credited to a Participant's Participant Account be credited to the Participant's Benefit Accounts. All payments of Benefit amounts under the Plan shall be debited against the appropriate Benefit Account.

5.4 CHANGES DURING PLAN YEAR. Except as provided in Sections 3.5 or 5.2 or in applicable law, a Participant shall not change (a) the amounts to be credited to a Participant Account during a Plan Year pursuant to Sections 5.1 or 5.2 or (b) the allocation of such amounts to Benefit Accounts during the Plan Year pursuant to Section 5.3.

ARTICLE 6
BENEFITS

6.1 AVAILABLE BENEFIT ELECTIONS. The benefits available for election pursuant to Article 3 shall be those provided through the Component Plans. The Participant cost of the Benefits will be determined by the Employer, and will be communicated to Participants from time to time.

Pursuant to a Participant's election of a Benefit provided under a Component Plan, the compensation of the Participant will be reduced by the amount necessary to provide such Benefit, and the Employer shall credit the amount of such salary reduction to the Component Plan on behalf of the Participant.

The Plan's Benefit options are as follows:

(a) Medical/Prescription Drug Coverage Account. Each eligible Participant may elect on his or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Medical/Prescription Drug Coverage Account for one of the medical/prescription drug coverage options designated by the Employer (as those options are described in the Component Plan(s) contained in the Appendix).

Notwithstanding any provision of this Plan or its Appendix, effective for Plan Years beginning on or after January 1, 1994, as required by Code '4980B(f), the Plan's coverage for costs of pediatric vaccines will not be less than the Plan's coverage, if any, for those costs at May 1, 1993. In addition, the Plan's terms will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

(b) Dental Coverage Account. If applicable, each eligible Participant may elect on his or her Election Form to have sufficient Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Dental Coverage Account for one of the dental coverage options designated by the Employer (as those options are described in the Component Plan(s) contained in the Appendix).

(c) Health Care Flexible Spending Account. Effective as of January 1, 2004, each Participant may elect on his or her Election Form to have Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 credited to his or her Health Care Flexible Spending Account according to guidelines established by the Administrator. The amount of Benefit Credits, if any, and Salary Reduction Contributions that may be credited to a Participant's Health Care Flexible Spending Account shall be no greater than two-thousand five hundred dollars ($2,500) per Plan Year (or any other amount per Plan Year determined by the Administrator and communicated to Employees from time to time).

Payments from this Account shall be made to the Participant in cash as a reimbursement for health-related expenses incurred during the Plan Year and after the Participant's Participation Date by the Participant or his or her spouse or dependents which:

(i) Are not covered, paid or reimbursed under any other health plan coverage;

(ii) Meet the criteria for deductible medical expenses under Code '213 (other than long term care expenses deductible thereunder) and for reimbursable medical expenses under Code '125; and

(iii) Are not taken as a deduction from income on the Participant's federal income tax return in any tax year.

For purposes of this subsection, the term "dependents" shall include any person who is a dependent as defined in '152 of the Code.

Notwithstanding any provision in the Plan to the contrary, any amount in a Participant's Health Care Flexible Spending Account at the end of a Plan Year against which amount liabilities have not been accrued during the Plan Year shall be forfeited. Unless the Administrator designates a later date, requests for reimbursement must be submitted by the ninetieth (90th) day following the earlier of (1) the close of the Plan Year or (2) the date the Participant ceases to be a Participant in the Health Care Flexible Spending Account Component Plan.

(d) Dependent Care Flexible Spending Account. Effective as of January 1, 2004, each Participant may elect on his or her Election Form to have Benefit Credits, if any, and/or Salary Reduction Contributions made pursuant to Section 5.2 in an aggregate amount not

to exceed five thousand dollars ($5,000) per calendar year (or, in the case of a married Participant filing a separate return for the taxable year in question, two thousand five hundred dollars ($2,500) per calendar year) credited to the Participant's Dependent Care Flexible Spending Account according to guidelines established by the Administrator. Payments from this Account shall be made to the Participant in the form of an Employer-provided payment in accordance with the following provisions which the Employer intends will be interpreted in a manner which is consistent with Code '129.

(i) A Participant is eligible to receive reimbursement for Employment Related Expenses (as defined below) incurred during the applicable Plan Year after the Participant's Participation Date in an amount not exceeding the remaining amount credited to the Participant's Dependent Care Flexible Spending Account at the time the claim for reimbursement is submitted.

(ii) The aggregate amount of reimbursements from the Dependent Care Flexible Spending Account which may be received by the Participant on a tax-free basis shall not exceed the Earned Income (as defined below) of the Participant, or, if the Participant is married at the end of the Plan Year, the Earned Income of the Participant's spouse, if less. Any amount of reimbursement received from the Dependent Care Flexible Spending Account which exceeds the lesser of the Earned Income of the Participant or, if the Participant is married at the end of the Plan Year, the Earned Income of the Participant's spouse, shall be taxable to the Participant.

For purposes of this subsection, "Earned Income" means wages, salaries, tips and other employee compensation, including net earnings from self-employment, for the Plan Year (computed without regard to any community property laws), and excluding pension and annuity income and income as a non-resident alien not connected with a United States business. The Earned Income of a spouse who is a full-time student at an educational institution or who is physically or mentally incapable of self care shall be deemed to be not less than two hundred dollars ($200) per month if there is one Qualifying Individual (as defined below) or four hundred dollars ($400) per month if there are two or more Qualifying Individuals.

(iii) For purposes of this Section, "Employment Related Expenses" for which reimbursement may be made from the Dependent Care Flexible Spending Account are amounts paid by the Participant for:

(A) expenses for Household Services (as defined below); and

(B) expenses for the care of a Qualifying Individual; so long as such expenses are incurred to enable the Participant or the Participant's spouse to be gainfully employed for a period for which there are one or more Qualifying Individuals with respect to that Participant.

(iv) For purposes of this Section, "Household Services" means ordinary and usual services necessary for the maintenance of the Participant's home performed in and about the home and which are attributable in part to the care of a Qualifying Individual, as more fully defined by applicable law.

(v) For purposes of this Section, "Qualifying Individual" means:

(A) a Dependent (as defined below) of the Participant who is under the age of thirteen (13) and for whom the Participant is entitled to a deduction under Code '151(c),

(B) a Dependent of the Participant who is under a Physical or Mental Incapacity (as defined below), or

(C) the spouse of a Participant who is under a Physical or Mental Incapacity. Physical or Mental Incapacity means a physical or mental defect which renders an individual incapable of caring for his or her hygienical or nutritional needs or which requires the full-time attention of another person for the individual's own safety or the safety of others.

In the case of divorced or separated parents, a child who (i) is under the age of thirteen (13) years or under a Physical or Mental Incapacity, (ii) received over one-half of his or her support during the Plan Year from parents who are divorced or legally separated under a decree of divorce or separate maintenance or who are separated under a written separation agreement, and (iii) is in the custody of one or both of his or her parents for more than one-half of the Plan Year, shall be a Qualifying Individual of the Participant for such Plan Year, but only if the Participant has custody of such child for a longer period during the Plan Year than the other parent.

Dependent means any individual who is a dependent within the meaning of Code '152.

(vi) Employment Related Expenses which are incurred for services outside the Participant's household will be entitled to reimbursement only:

(A) if incurred for the care of a Qualifying Individual who is a Dependent of the Participant who is (i) under the age of thirteen (13) years and with respect to whom the Participant is entitled to a deduction on his or her federal income tax return under '151(c) of the Code, or (ii) another Qualifying Individual who regularly spends at least eight (8) hours each day in the Participant's household; or

(B) if incurred for services performed outside the Participant's household by a Dependent Care Center (as defined below), only if such Center complies with the applicable laws and regulations of a State or unit of local government and care is rendered to (i) a Qualifying Individual who is under the age of thirteen (13) and with respect to whom the Participant is entitled to a deduction on his or her federal income tax return under '151(c) of the Code, or (ii) another Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant's household. A "Dependent Care Center" means any facility which (a) provides care for more than six (6) individuals (other than individuals who reside at the facility), and (b) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(vii) Any provision of the Plan to the contrary notwithstanding, no payments shall be made to a Participant for Employment Related Expenses rendered by an individual:

(A) for whom the Participant or his or her spouse is entitled to a deduction under '151(c) of the Code, or

(B) who is a son, stepson, daughter or stepdaughter of the Participant who is under the age of nineteen (19) at the end of the Plan Year.

(viii) Any provision of the Plan to the contrary notwithstanding, any amount in a Participant's Dependent Care Flexible Spending Account at the end of the Plan Year against which amount liabilities have not been accrued during the Plan Year shall be forfeited. Requests for reimbursement must be submitted by the ninetieth (90th) day following the close of the Plan Year or by such later date as is designated by the Administrator.

(ix) Pursuant to Code '129, on or before each January 31 during which this Plan is in effect, the Administrator shall furnish to each Participant a written statement, which may be the Participant's W-2, showing the amounts paid or expenses incurred by the Employer in providing dependent care assistance to such Participant during the previous calendar year.

(x) No amount shall be reimbursed to a Participant unless he or she provides the Plan Administrator with the name, address and tax identification number of the person performing services or if the service provider is an organization exempt under Code '501(a), the name and address of such service provider. This provision shall not apply if the Participant exercises due diligence in attempting to provide this information.

6.2 UNUSED BENEFIT CREDITS. Benefit Credits, if any, not otherwise utilized pursuant to this Article will be forfeited to the Employer, unless, notwithstanding anything herein to the contrary, the Employer in its discretion (and in accordance with the Code) determines to pay such amounts in cash to the Participant, or to otherwise apply such amounts for the benefit of the Participant.

6.3 UNUSED FLEXIBLE SPENDING BALANCES. Flexible Spending Account balances, if any, not otherwise utilized pursuant to this Article will be forfeited to the Employer.

6.4 INSURANCE CONTRACTS. The Employer has the right to enter into contracts with one or more insurance companies for the purpose of providing any Benefits under the Plan and to replace any of such insurance companies from time to time. Any dividends, retroactive rate or other refunds of any type which may become payable under any such insurance contracts shall not be assets of the Plan but shall be the property of, and shall be retained by, the Employer. If any Benefit hereunder is intended to be provided under an insurance contract, a Participant or eligible dependent may look only to the insurance company for payment of that benefit.

6.5 SOURCE OF BENEFITS. The Employer shall pay any Benefits intended to be self-funded to which a Participant is entitled under this Plan from its general assets.

6.6 MAXIMUM CONTRIBUTIONS AND BENEFITS. The maximum amount of contributions and Benefits made available hereunder to any one Participant in any one Plan Year shall be limited as provided in the Code, as it may be amended from time to time.

6.7 REQUESTS FOR REIMBURSEMENT. Any Participant who wishes to receive a reimbursement from his or her Health Care Flexible Spending Account or Dependent Care Flexible Spending Account must submit to the Administrator (or Insurer or designee of the Administrator, if applicable) a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator (or Insurer or designee of the Administrator, if applicable) shall deem necessary as to the amount, nature and payment of such reimbursement. Unless a later date is designated by the Administrator, a reimbursement request must be submitted by the ninetieth (90th) day following the close of the Plan Year during which the expense was incurred (or, if earlier and only for purposes of the Health Care Flexible Spending Account, by the ninetieth (90th) day following the date the Participant is no longer a Participant in the Health Care Flexible Spending Account Component Plan).

6.8 MINIMUM REIMBURSEMENT AMOUNTS. The Administrator (or Insurer or designee of the Administrator, if applicable) may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement in order for reimbursement to be made hereunder.

6.9 REQUESTS EXCEEDING ACCRUED DEPENDENT CARE FLEXIBLE SPENDING BALANCE. Requests from a Participant for reimbursement of eligible expenses which exceed the accrued balance in the Participant's Dependent Care Flexible Spending Account will be held in a suspense account until the Account has been credited with sufficient amounts to permit such reimbursement, provided that such additional credits are made within the Plan Year to which the reimbursement is chargeable.

6.10 REQUESTS EXCEEDING ACCRUED HEALTH CARE FLEXIBLE SPENDING BALANCE. Requests from a Participant for reimbursement of eligible expenses which exceed the accrued balance in the Participant's Health Care Flexible Spending Account will be paid at any time during the Plan Year upon submission of satisfactory documentation of the expense, but only up to the maximum annual amount elected by the Participant for the Plan Year, notwithstanding that such account has not been credited with sufficient Salary Reduction Contributions to permit such reimbursement.

ARTICLE 7
HEALTH INFORMATION PRIVACY

7.1 SCOPE OF ARTICLE. This Article 7 is intended to provide for the Plan's compliance with all applicable requirements of the final Regulations entitled Standards for Privacy of Individually Identifiable Health Information issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations").

Notwithstanding the general Effective Date for this amendment and restatement, this Article is effective beginning April 14, 2003 (or such later date or dates on which the Privacy Regulations become applicable to the Plan). As of the effective date of this Article, each Component Plan which is a group health plan subject to the Privacy Regulations will comply with all applicable requirements of the Privacy Regulations, as provided in this Article and in the Privacy Regulations and as interpreted pursuant to any subsequent authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy Regulations and any provision of this Plan, the Privacy Regulations will control. Also, any amendment or revision or authoritative interpretation of the Privacy Regulations is incorporated into the Plan as of the effective date of that guidance.

7.2 PROTECTED HEALTH INFORMATION. For purposes of the Health Plan, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Health Plan.

7.3 DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER. The Plan will disclose Protected Health Information to the Employer only as follows:

(a) Summary Health Information. The Plan, or a health insurance issuer or HMO with respect to the Plan may disclose Protected Health Information that is summary health information (as defined in '164.504(a) of the Privacy Regulations) to the Employer, if the Employer requests the summary health information for the purpose of:

(i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or

(ii) Modifying, amending or terminating the Plan.

(b) Enrollment Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(c) Other Disclosures to Employer. Except as provided in Sections 7.3(a) and 7.3(b), or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Employer and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Plan to the Employer only if the Employer requires the Protected Health Information to administer the Plan. The Employer, by signing this document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted or required by the Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(iii) will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer;

(iv) will report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted under the Plan of which it becomes aware;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(ix) if feasible, will return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) will ensure that the adequate separation of the Plan and the Employer as required in this Article is established.

(d) Prohibited Disclosures. The Plan will not disclose Protected Health information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

7.4 SEPARATION OF HEALTH PLAN AND THE COMPANY. The Employer has designated and trained employees of the Employer in its human resources, finance and executive management departments who will be the only employees of the Employer who will have access to Protected Health Information. These employees will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the Employer provides for Plan.

The Employer will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remediating and disciplining any alleged instances of noncompliance with the requirement that employees of the Employer who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Article.

7.5 PRIVACY NOTICE. The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

ARTICLE 8
ADMINISTRATION

8.1 THE ADMINISTRATOR. Except as to those functions delegated to the Recordkeeper or an Insurer by the Administrator and except as to those functions reserved within the Plan or a Component Plan to the Recordkeeper or an Insurer, the Administrator shall control and manage the operation and administration of the Plan. The Administrator shall be the District or such other person or committee as may be appointed from time to time by the District to administer the Plan. The Administrator or any person who is a member of a committee that is appointed hereunder to be the Administrator may or may not be a Participant in the Plan.

8.2 ADMINISTRATIVE RULES AND DETERMINATIONS. Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator shall have the exclusive right (except as to matters delegated to the Recordkeeper or an Insurer by the Administrator and except as to matters reserved to the Recordkeeper or an Insurer by the Plan or a Component Plan) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following powers and duties:

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

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

(c) To decide on questions concerning the Plan and the eligibility of any employee to participate in the Plan, in accordance with the provisions of the Plan; and

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

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

8.3 DELEGATION AND RELIANCE. The Administrator may employ the services of such firms or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. Without limiting the generality of the preceding sentence, the Administrator shall specifically have the power to delegate to any Insurer the power and responsibility to determine claims and benefits under any policy issued by such Insurer, and the Administrator shall be protected in relying upon such Insurer's determinations. The Administrator (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including employees of the Employer who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

8.4 INDEMNIFICATION AND INSURANCE. To the extent permitted by law, neither the Administrator, nor any other person performing duties hereunder, shall incur any liability for any act done, determination made or failure to act, if in good faith, and, if the Employer is not the Administrator, the Employer shall indemnify the Administrator, its members and such other persons against any and all liability which is incurred as a result of the good faith performance or non-performance f their duties hereunder. Nothing in this Plan shall preclude the Employer from purchasing liability insurance to protect such persons with respect to their duties under this Plan.

8.5 COMPENSATION, EXPENSES AND BOND. The Administrator shall serve without compensation for its services as such, but, if the Employer is not the Administrator, all reasonable expenses incurred in the performance of its duties shall be paid by the Employer. Unless otherwise required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

8.6 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER. All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by the Employer or from Participant contributions, as determined by the Employer.

ARTICLE 9
CLAIMS PROCEDURE

9.1 CLAIMS PROCEDURE.

(a) Initial Claim. If a Participant or a Participant's spouse, dependent or beneficiary (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may file a claim with the Recordkeeper. The Recordkeeper shall review the claim itself or appoint an individual or an entity to review the claim. The Claimant shall be notified within ninety (90) days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Recordkeeper or appointee of the Recordkeeper prior to the end of the ninety (90) day period stating that circumstances require an extension of the time for decision, such extension not to extend beyond the day which is one hundred eighty (180) days after the day the claim is filed. The notice of the decision shall be in writing, sent by mail to the Claimant's last known address, and, if the notice is a denial of the claim, the notice shall contain the following information:

(1) the specific reasons for the denial;

(2) a specific reference to pertinent provisions of the Plan on which the denial is based;

(3) if applicable, a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is necessary; and

(4) an explanation of the Plan's claims review procedure.

(b) Review Procedure. A Claimant is entitled to request a review by the Recordkeeper of any denial of the Claimant's claim. The request for review must be submitted to the Recordkeeper in writing within sixty (60) days of mailing of notice of the denial. Absent a request for review within the sixty (60) day period, the claim will be deemed to be conclusively denied. The review of a denial of a claim shall be conducted by the Recordkeeper or an individual or entity appointed by the Recordkeeper. The reviewer shall afford the Claimant an opportunity to review all pertinent documents and submit issues and comments in writing and shall render a review decision in writing, all within sixty (60) days after receipt of a request for a review, provided that, where not prohibited by law, the reviewer may extend the time for decision by not more than sixty (60) days upon written notice to the Claimant. The Claimant shall receive written notice of the reviewer's decision, together with specific reasons for the decision and reference to the pertinent provisions of the Plan.

(c) Preemption of State Law. With respect to any insured benefit under this Plan, nothing in this Article shall be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this Article.

ARTICLE 10
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT. The District reserves the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan or the insurance contracts maintained to provide Benefits under the Plan.

10.2 TERMINATION. The District reserves the power to discontinue or terminate the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the District, the Plan shall terminate unless it is continued by a successor to the District.

10.3 REDUCTION OR TERMINATION OF BENEFITS. Participants in the Plan, including retirees, if any, have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to Benefits with respect to covered events giving rise to Benefits and occurring prior to the effective date of the Plan termination or applicable Plan amendment.

10.4 EFFECTIVE DATES. Any such amendment, discontinuance or termination shall be effective at such date as the District shall determine.

ARTICLE 11
GENERAL PROVISIONS

11.1 NO EMPLOYMENT CONTRACT. Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any employee, or as a right of any employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees with or without cause.

11.2 APPLICABLE LAW. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and, where not preempted by federal law, the laws of the State of New York.

11.3 NON-ALIENATION PROVISIONS. Unless lawfully permitted under the terms of a Component Plan or lawfully permitted by the payer of the Benefit, no Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

11.4 PAYMENTS TO INCOMPETENTS. If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to any other person for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and the Employer.

11.5 INABILITY TO LOCATE RECIPIENT. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so

due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited eighteen (18) months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

11.6 PLAN COMMUNICATIONS. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Administrator.

11.7 SOURCE OF BENEFITS. The District (and any insurance contracts purchased or held by the District) shall be the sole source of Benefits under the Plan. No Employee or other person shall have any right to, or interest in, any assets of the District upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or other person.

11.8 INTERPRETATION. This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code.

11.9 SUBROGATION. As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverages, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverages to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

11.10 MEDICARE AND MEDICAID SECONDARY PAYOR RULES. The Plan at all times will be operated in accordance with any applicable Medicare and Medicaid secondary payor and non-discrimination rules, including, but not limited to the rules of '1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to,

rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals.

11.11 NON-DISCRIMINATION AND OTHER RULES. All benefits and elections under this Plan shall be subject to all applicable non-discrimination and other rules under the Code and other applicable law (e.g., the non-discrimination rules of Code ''105(h), 125, 129 and 79, the Code '125 key employee 25% concentration rules, the Americans with Disabilities Act rules, etc.) and the Employer shall test the Plan for compliance with such rules and may take any actions it considers advisable for the purpose of ensuring the Plan's compliance with such rules.

11.12 HEALTH CARE CONTINUATION COVERAGE RULES. Notwithstanding any provision of the Plan to the contrary, the Employer shall provide Participants and Dependents with all health care continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any other similar, applicable state law.

11.13 HIPAA RULES. Notwithstanding any provision of the Plan to the contrary, the Plan shall be administered at all times in accordance with the preexisting condition limitation, creditable coverage, certificate of coverage delivery, special enrollment period, notification, administrative simplification and other applicable requirements of the Health Insurance Portability and Accountability Act of 1996.

11.14 STATUTE OF LIMITATIONS. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than twelve (12) months after the final review decision by the Plan Administrator has been rendered (or deemed rendered).

11.15 COORDINATION OF BENEFITS. The coordination of benefits provisions specified in the Appendix, as interpreted by the Plan Administrator in its discretion, shall control coordination of benefits situations involving the Plan and other payors.

IN WITNESS WHEREOF, the District has caused this document to be executed and its seal to be affixed hereto, effective as specified herein.

ATTEST/WITNESS:

_____
Signature

Print Name:_____

GREAT NECK UNION FREE SCHOOL DISTRICT

By:_____(SEAL)
Signature

Print Name: Lawrence R. Gross, President
Great Neck Board of Education

Date:_____