Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 15—Cafeteria Plan

PROPOSED AMENDMENT

1 CSR 10-15.010 Cafeteria Plan. The commissioner is amending Section (2) and deleting Appendices A, B, and C and replacing with Appendix A Cafeteria Plan for the Employees of the State of Missouri Plan Document.

PURPOSE: This amendment is being filed to comply with federal regulations of Section 125 of the IRS Code.

PURPOSE: This rule complies with the statutory requirement that the commissioner file a written plan document in accordance with Chapter 536, RSMo, and payroll deduction qualifications in accordance with Chapter 33, RSMo.

(2) The commissioner of administration shall maintain the cafeteria plan, the dependent care assistance plan**,** and the flexible medical benefits plan, in written form, denominated as the Missouri State Employees' Cafeteria Plan *[(Appendix A), the Missouri State Employees' Dependent Care Assistance Plan (Appendix B) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C), which are included herein, for Plan Year 1998 and years following]* **Document attached as Appendix A**.

[APPENDIX A
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN

The State of Missouri through the Office of Administration hereby amends and restates the Missouri State Employees' Cafeteria Plan (hereinafter called the MSECP) effective January 1, 2009. The provisions of the MSECP, as set forth in this document and the attendant documents for the Missouri State Employees' Dependent Care Assistance Plan (Appendix B, hereinafter called the MSEDCAP) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C, hereinafter called the MSEFMBP), shall be applicable to each employee of the State of Missouri unless he/she elects not to participate in the MSECP beginning with Plan Year 2009.

ARTICLE ONE
DEFINITIONS

1.01 "Account" means the account(s) maintained under the MSECP by the Plan Administrator to which allocations of employer contributions are made for each participant as required by the MSECP and from which payments, as permitted by the MSECP, shall be paid.

1.02 "Employee" means any person employed by the employer.

1.03 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.

1.04 "Office of Administration" means the Office of Administration of the State of Missouri.

1.05 "Participant" means any employee who has not waived coverage and is participating in the MSECP.

1.06 "Plan Administrator" means the Office of Administration or its duly appointed designee to administer the MSECP.

1.07 "Plan Year" means the calendar year.

1.08 "Spouse or Dependent" means the spouse or dependent of a participant within the meaning of Section 125 and 152 of the Internal Revenue Code.

1.09 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

1.10 "Waive coverage" means to formally opt-out of participation in the MSECP sections 4.01(a), 4.01(b), 4.01(c), 4.01(d), 4.01(e), and/or 4.01(g) in writing or online.

ARTICLE TWO
STATEMENT OF PURPOSE

2.01 This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. The purpose of the MSECP is to provide to participants the tax savings opportunities permissible under Section 125 of the Internal Revenue Code.

2.02 The MSECP will be nondiscriminatory, as such term is used in Section 125 of the Internal Revenue Code, and the employer will take such action as may be necessary to maintain the MSECP as nondiscriminatory under said code section.

ARTICLE THREE
ELIGIBILITY AND PARTICIPATION

3.01 The MSECP does not apply to any individual who terminated employment with the employer prior to the effective date of this amended and restated MSECP (January 1, 2009) unless such individual becomes reemployed by the employer on or after such effective date.

3.02 Any employee who is on the payroll of the employer as of the effective date is eligible to become a participant on the effective date. Any employee, except any employee subject to the provisions of the MSECP, section 3.03, who chooses not to become a participant at the beginning of each Plan Year will not again become eligible for participation in the MSECP until the beginning of the next Plan Year, except as provided under the MSECP, section 3.09.

3.03 Any person who becomes an employee after the effective date shall be automatically enrolled unless waiving coverage in the MSECP within thirty-one (31) days from the date of employment. Such employee shall become a participant on the first day of the first full month coincident with or next following the date of employment.

3.04 Subject to the provisions of the MSECP, section 3.05, an eligible employee shall automatically become a participant of 4.01(a), 4.01(d), 4.01(e), and 4.01(g) for any and each Plan Year unless waiving coverage of the specific plan, and agree to and authorize the reduction of the participant's compensation by a permissible amount for credit to the participant's account as maintained by the Plan Administrator. For purposes of the first sentence of this paragraph, the term "permissible amount"

(unless and until subsequently changed by appropriate action of the Office of Administration and notice of such change is provided to all participants) means an amount(s) determined by the participant which is (are):

(a) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Medical Insurance benefit described in the MSECP, section 4.01(a);

(b) not more than five thousand dollars ($5,000) in the case of the Flexible Medical Benefits benefit described in the MSECP, section 4.01(b);

(c) not more than five thousand dollars ($5,000) in the case of the Dependent Care Assistance benefit described in the MSECP, section 4.01(c);

(d) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Dental Insurance benefit described in the MSECP, section 4.01(d);

(e) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Vision Care Insurance benefit described in the MSECP, section 4.01(e).

(f) not more than the expected sum of the total cost or premium during the Plan Year in the case of any other product or products eligible under Section 125 of Title 26 of the United States Code, as described in MSECP section 4.01(g).

In the event of any change in the permissible amount, the resulting new permissible amount must be nondiscriminatory (as defined in Section 125 of the Internal Revenue Code) in its application to participants. In the case of the insurance benefits or products described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) the permissible amount must be consistent with the actual rate in effect at the start of the coverage period or it will automatically be changed to reflect the actual rate in effect at the start of the coverage period.

3.05 Except as otherwise provided in the MSECP, section 3.03, the waiving of elections and flexible benefit authorizations required by the provision of the MSECP section 3.04 must be submitted to the Plan Administrator by a date established by the Plan Administrator which shall be prior to the first day of the applicable Plan Year. Any employee who becomes a participant pursuant to the MSECP, section 3.03 shall be allowed to submit the required waiver request with the Plan Administrator no later than thirty-one (31) days from the date of employment in order to waive participation from the program.

3.06 Any employee who fails to make an election when first eligible under section 3.04 or 3.05 shall be deemed to have elected to reduce his or her cash compensation in an amount equal to the total of the amounts for coverage in effect on the first day of participation of the applicable Plan Year described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) and to have such amounts pay for coverage described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent he or she has elected such coverage. Further, any such employee who fails to make an election under section 3.04 or 3.05 shall be deemed to have elected to not receive any benefits under the coverage described in sections 4.01(b) and 4.01(c) and to receive the balance of his or her entire compensation in cash.

3.07 Any employee duly enrolled and participating in one or more of the insurance plans described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be considered to have submitted the required authorization to continue participation in the same plan(s) for the subsequent Plan Year at an amount equal to the total expected annual cost or premium based on the rate in effect as of January 1 of that subsequent Plan Year. A participant who does not wish to continue an insurance plan under the Cafeteria Plan for a subsequent Plan Year must so specify on the appropriate election form or in an alternate prescribed manner prior to the start of the subsequent Plan Year.

3.08 Any employee who elects pursuant to an authorization under section 3.05 of this Plan an amount under the Flexible Medical Benefits described in the MSECP, section 4.01(b) or the Dependent Care Assistance plan described in the MSECP, section 4.01(c) for any Plan Year shall be deemed to have also made an election to receive benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent the participant's share of premiums (if any) for any benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g).

3.09 Permitted Election Changes.

(a) Following the commencement of any Plan Year for which an employee participates in the MSECP, the authorization filed with the Plan Administrator for such Plan Year may neither be changed nor revoked except as provided in this section. An employee may revoke an election during a period of coverage and make a new election for the remainder of the relevant coverage period only as provided in paragraphs (b) through (h) of this section. Such revocation and new election must be made within sixty (60) days of an event described in (b) through (g) of this section and is made on account of and corresponds to the event.

(b) Special enrollment rights. An employee may revoke an election for a benefit described under Article Four, section 4.01(a), 4.01(d), or 4.01(e) and make a new election that corresponds with the special enrollment rights provided in Internal Revenue Code Section 9801(f) (HIPAA), whether or not the change in election is permitted under paragraph (c) of this section.

(c) Changes in status.

1. An employee may revoke an election and make a new election for the remaining portion of the period if, under the facts and circumstances—

(i) A change in status occurs; and

(ii) The election change satisfies the consistency requirement in paragraph (c)(3) of this section.

2. Change in status events. The following events are changes in status for purposes of this paragraph (c)—

(i) Legal marital status. Events that change an employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(ii) Number of dependents. Events that change an employee's number of dependents (as defined in Internal Revenue Code Section 152), including birth, adoption, placement for adoption (as defined in regulations under Internal Revenue Code Section 9801), or death of a dependent, or in the case of Dependent Care, a change in the number of qualifying individuals as defined in the Internal Revenue Code Section 21(b)(1);

(iii) Employment status. Any of the following events that change the employment status of the employee, spouse, or dependent is considered a change in status. A termination, commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence of more than thirty (30) days, change in worksite, or any other employment status change that affects eligibility under this plan or employee benefit plan of the employer of the spouse or dependent;

(iv) Dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage; and

(v) Residence. A change in the place of residence of the employee, spouse, or dependent.

3. Consistency rule—

(i) General rule. An employee's revocation of a Cafeteria Plan election during a period of coverage and a new election for the remaining portion of the period (referred to as an "election change") is consistent with a change in status if, and only if—

(A) The change in status results in the employee, spouse, or dependent gaining or losing eligibility for coverage under either the Cafeteria Plan or a plan of the spouse's or dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

(ii) If the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election under the cafeteria plan to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment, or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel accident or health coverage for any other dependent, for the employee, or for the employee's spouse fails to correspond with that change in status.

In addition, if an employee, spouse, or dependent gains eligibility for coverage under a plan provided by the employer of the spouse or dependent as a result of a change in marital status or a change in employment status, the employee may cease or decrease coverage for that individual only if coverage for that individual becomes applicable or is increased under that employer's plan.

(iii) A change in status results in an employee, spouse, or dependent gaining (or losing) eligibility for coverage under a plan only if the individual becomes eligible (or ineligible) to participate in the plan. An individual is considered to gain or lose eligibility for coverage if the individual becomes eligible (or ineligible) for a particular package option under a plan (e.g., a change in status results in an individual becoming eligible for a managed care option or an indemnity option). If, as a result of a change in status, the individual gains eligibility for elective coverage under a plan of the spouse's or dependent's employer, the consistency rule of this paragraph (c)(3)(i) is satisfied only if the individual elects the coverage under the spouse's or dependent's employer.

(iv) Exception for COBRA. Notwithstanding paragraph (c)(3)(i) of this section, if the employee, spouse, or dependent becomes eligible for continuation coverage under any of the employer's health plans described in sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) as provided under COBRA or any similar state law, the employee may increase payments under the Cafeteria Plan in order to pay for the continuation coverage.

(v) Except as provided in this paragraph the provisions of paragraph (c) apply to an election change under a benefit described under Article 4.01(b). A participant may reduce an election for a benefit described under 4.01(b) due to a change in status if and only if the employee's legal martial status changes due to death, divorce, annulment, or legal separation, or there is a reduction in the number of dependents of the employee (as defined in section 152 of the Internal Revenue Code) due to death.

(d) Judgment, decree, or order. This paragraph (d) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of the Employee Retirement Income Security Act of 1974) that requires accident or health coverage for an employee's child. Notwithstanding the provisions of paragraph (c) of this section, an employee may—

1. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to provide coverage for the child if the order requires coverage under the employee's plan; or

2. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage for the child if the order requires the former spouse to provide coverage.

(e) Entitlement to Medicare or Medicaid. If an employee, spouse, or dependent becomes entitled to coverage (i.e., 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), an employee may make an election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage of that employee, spouse, or dependent under the accident or health plan. In addition, if an employee, spouse, or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, an employee may make an election change to commence or increase coverage under a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g).

(f) Coverage or cost changes. Changes allowed under this section are not applicable to Flexible Medical Benefits as described in section 4.01(b). Therefore, no changes to an election for Flexible Medical Benefits is allowed due to events described in this section (f).

1. Cost changes. A participant's plan described under Article 4.01(a), 4.01(d), 4.01(e), or 4.01(g) will automatically be changed to reflect a change in the cost of coverage. Alternatively, if the premium amount significantly increases a participant may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

2. Coverage changes. If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may revoke his/her election under the plan and may make a new election on a prospective basis for coverage under another plan option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primary care physician would not be a significant curtailment because it does not affect participants in general.

Addition (or elimination) of a plan option providing similar coverage. If during a period of coverage the plan adds a new plan option or other coverage option (or eliminates an existing plan option or other coverage option) affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other plan options providing similar coverage.

3. Change in coverage of spouse or dependent under other employer's plan. An employee may make a prospective election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) that is on account of and corresponds with an election made under the plan of the spouse's, former spouse's or dependent's employer if the period of coverage under the cafeteria plan or qualified plan of the spouse's, former spouse's, or dependent's employer only allows elections for periods of coverage different than the Plan Year for the MSECP.

(g) Special requirements concerning the Family and Medical Leave Act.

An employee taking FMLA leave may revoke an existing election for the remaining portion of the coverage period. Upon returning from FMLA leave, an employee may choose to be reinstated in any benefit described under this plan if such coverage was terminated during the FMLA leave (either by revocation or nonpayment of premiums). Such reinstatement will be on the same terms as prior to taking FMLA leave. However, the employee has no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year. In addition to the rights granted under FMLA, such an employee has the right to revoke or change elections under the same terms and conditions as are available to employees participating in the Cafeteria Plan who are not on FMLA leave.

If an employee's coverage under a benefit described in section 4.01(b) or 4.01(c) terminates while the employee is on FMLA leave, the employee is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If that employee subsequently elects to be reinstated in a benefit previously terminated upon return from FMLA leave for the remainder of the Plan Year, the employee may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. Further, the employee is not entitled to greater benefits relative to premiums paid than an employee who has been continuously working during the Plan Year. Therefore, if an employee elects to be reinstated in a benefit described above upon return from FMLA leave, the employee's coverage for the remainder of the Plan Year is equal to the employee's election for the 12-month period of coverage (or such shorter period as provided under section 3.03 or this section 3.09), prorated for the period during the FMLA leave for which no premiums were paid, and reduced by prior reimbursements.

(h) Effective date of election changes.

Any increase in the election amount designated by a participant made due to a change in status may include only those expenses which the participant expects to incur at a time during the period of coverage subsequent to the effective date of the increase. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(b) or 4.01(c) shall be effective with the first day of the month coincident with or next following the Plan Administrator's receipt and approval of written notification of the new election. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be effective with the first required premium payment after the event.

3.10 If participation terminates due to a separation of service and the individual returns to eligible employment within thirty (30) days in the same Plan Year, then the participant's election will be reinstated as it was immediately prior to the separation of service. If participation terminates due to a separation of service and the individual returns to eligible employment after thirty (30) days in the same Plan Year, then the participant may make a new election for the remainder of the Plan Year. If salary reduction contributions were not made during the separation of service, the participant will not be able to be reimbursed for expenses incurred under benefits described under sections 4.01(b) and 4.01(c) during the separation.

3.11 A claim that is determined to be fraudulent by the plan administrator shall be denied. The administrator shall refer any fraud to the Office of Administration which will forward the matter to the employee's department and appropriate law enforcement for further action. The employee making a fraudulent claim shall be barred from future participation in the plan.

ARTICLE FOUR
AVAILABLE SELECTION OF PLAN CATEGORIES

4.01 In general, employees are automatically enrolled into 4.01(a), 4.01(d), 4.01(e), and 4.01(g) unless waiving coverage in writing and may choose to participate in 4.01(b) and 4.01(c) offered under the MSECP:

(a) State-Sponsored Medical Insurance—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides medical benefits or health insurance to or on behalf of any employee or spouse or dependent in the event of illness or personal injury to the employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the

Missouri Consolidated Health Care Plan (MCHCP), Missouri Department of Transportation and Missouri State Highway Patrol Medical & Life Insurance Plan, or Conservation Employees Benefits Plan Trust Fund, or is obtained by competitive bid and is not duplicative of any other plan provided by the State of Missouri. This article shall expressly include any Health Maintenance Organization (HMO) to which the employer makes a contribution on behalf of a participant;

(b) Flexible Medical Benefits—This category provides for payment to the participant of the cost of medical care for the participant or spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEFMBP (Appendix C), established in conjunction with the MSECP;

(c) Dependent Care Assistance—This category provides for payment to the participant of employment-related expenses for the care of the spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEDCAP (Appendix B) established concurrently with the MSECP;

(d) State-Sponsored Dental Insurance—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;

(e) State-Sponsored Vision Care Insurance—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides vision care benefits or vision care insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;

(f) Cash; and

(g) Other Products—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor.

ARTICLE FIVE
GENERAL PROVISIONS REGARDING PLANS

5.01 No expenditure of any nature shall qualify for payment or reimbursement under the MSECP unless the expense is for the participant, the participant's spouse, or the participant's dependent. Such expenses must be incurred during the participant's period of coverage and must be related to the particular plan selection made by the participant at the time of enrollment for the period of coverage. For purposes of the MSECP, a period of coverage is any Plan Year (including an initial short Plan Year) or, in the case of participants subject to the MSECP, section 3.03, a period of coverage extends from the first day of the month coincident with or next following the hire date through the end of the Plan Year unless waiving coverage of the plan. In the case of medical expenses, an expense will be considered as having been incurred at the time the medical care related to the expense is provided and not at the time the expense is charged, billed or paid. Similarly, in the case of dependent care expenses, an expense will be considered as having been incurred at the time the dependent care related to the expense is provided.

5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall provide to each person who was a participant in the MSEFMBP or the MSEDCAP at any time during the Plan Year an accounting statement reflecting contributions to and distributions from each account established for the participant during the Plan Year, including such other information as may be required by regulations promulgated by the Secretary of the Treasury or his/her delegate.

ARTICLE SIX
CONTRIBUTIONS TO PARTICIPANT ACCOUNTS

6.01 Except as provided in the MSEFMBP, section 6.03 or Article VII, contributions to the account of each participant shall be made only by the employer and shall be made as follows: On the participant's regular pay date during each Plan Year, the employer shall cause to be contributed for credit to the account of said participant an amount equal to the sum of the permissible amounts elected by the participant for all plans selected for the Plan Year divided by the number of the participant's regular pay dates in the Plan Year subsequent to the participant's effective date of participation.

6.02 Any funds remaining to the credit of a participant's account as of the close of business on December 31 of a Plan Year shall be forfeited and revert to the employer; provided, however, that all such funds shall be held for a period of not less than ninety (90) days following the end of the Plan Year and be applied to the payment or reimbursement of covered expenses that the participant incurred during the Plan Year that the funds were credited and to the extent that claims for payment or reimbursement, accompanied by appropriate evidence of the related expenditures or obligations, are submitted to the Plan Administrator within the required period following the end of the Plan Year.

ARTICLE SEVEN
ADMINISTRATION

7.01 Neither the employer nor the Plan Administrator makes any assurance to any participant that participation in the MSECP (or the related MSEDCAP or MSEFMBP) is appropriate for any participant nor guarantees any loss which may result because of any participant's participation in the MSECP.

7.02 The Plan Administrator shall make all determinations required respecting administration of the MSECP, including determinations as to the right of any person to a plan under the MSECP. Such determinations are final as approved by the Plan Administrator.

7.03 Any decision by the Plan Administrator regarding a denial of a claim for benefits or a change of election by a participant shall be stated in writing by the Plan Administrator and be delivered to the participant within thirty (30) days of the receipt by the Plan Administrator of the claim or change request; such notice shall set forth the specific reason for any denial. Any participant may file a written request with the Plan Administrator for a review of the denied claim for benefits or change of election within sixty (60) days of the notice of the denial. The Plan Administrator will notify the participant of its decision in writing within sixty (60) days of the request for review.

7.04 The Plan Administrator shall exercise a reasonable level of authority and responsibility in order to comply with the terms of the MSECP relating to the records of participants and amounts payable under the MSECP.

7.05 The Plan Administrator shall construe and interpret the MSECP, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder.

7.06 Premium amounts returned by a medical or insurance provider or any benefit amount erroneously withheld and returned to the State by the Plan Administrator shall be deposited into the MSECP account. Allowable refunds, less required federal, state and Social Security tax withholdings, shall be issued by check payable to the participant from the MSECP account and wage reporting for tax purposes will be corrected.

7.07 Vendors of products included in 4.01(g) must comply with 1 CSR 10-4.010 and 1 CSR 10-15.010, and also agree to fees for the cost of administration, set by the Commissioner of Administration.

ARTICLE EIGHT
MISCELLANEOUS

8.01 No participant shall have any right to or interest in any assets of the MSECP upon termination or otherwise except as provided under the MSECP, and then only to the extent of the benefits payable under the MSECP to such participant. All payments of benefits provided under the MSECP shall be made solely out of the assets of the employer.

8.02 Benefits payable under the MSECP shall not be subject to, in any manner, voluntary anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind.

8.03 Products included under 4.01(g) are not endorsed or provided by the State of Missouri. Solicitation by a vendor of signed employee applications or memberships may not be performed in State facilities at any time with the exception of qualified vendor products for the cafeteria plan and regulations under 1 CSR 10-15.010(3).

ARTICLE NINE
AMENDMENTS AND TERMINATION

9.01 The employer reserves the right to make amendments to the MSECP at any time. Any amendment to the MSECP may be made with retroactive effect if determined to be necessary or desirable to comply with any applicable law or applicable regulation.

9.02 The employer may terminate the MSECP at any time.

9.03 Upon the expiration or termination of a Plan Year, the accounts of all participants affected thereby shall continue to be held by the Plan Administrator for distribution in accordance with the purposes and relevant provisions of the MSECP. If not so distributed within one hundred twenty (120) days following the last day of the expired or terminated Plan Year, balances shall thereupon be forfeited and revert to the employer.

APPENDIX B
MISSOURI STATE EMPLOYEES' DEPENDENT CARE ASSISTANCE PLAN

The State of Missouri hereby establishes for the benefit of its employees a Dependent Care Assistance Plan (hereinafter called the MSEDCAP) intended to conform to the requirements of paragraphs (2) through (8) of subsection (d) of Section 129 of the Internal Revenue Code, and in association with the Missouri State Employees' Cafeteria Plan, (Appendix A; hereinafter called the MSECP), established concurrently herewith.

ARTICLE ONE
DEFINITIONS

1.01 "Dependent Care Assistance" means the direct payment to the participant or reimbursement to the participant for the payment of those services which are considered employment related expenses under Section 21(b)(2) of the Internal Revenue Code (relating to expenses for household and dependent care services necessary for gainful employment).

1.02 "Incurred" means when the participant is provided with the dependent care service that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the dependent care.

1.03 All terms defined in the related MSECP document, wherever used in this MSEDCAP document, shall have the same meaning as required by the definition set forth in said MSECP document.

ARTICLE TWO
STATEMENT OF PURPOSE

2.01 The purpose of this MSEDCAP is to make possible the inclusion of Dependent Care Assistance in the group of benefits which may be selected by participants of the related MSECP and to satisfy the requirement of a separate written plan for a dependent care assistance program as set forth in Section 129(d)(1) of the Internal Revenue Code.

ARTICLE THREE
ELIGIBILITY

3.01 Any person who is eligible to participate in the related MSECP is eligible to select Dependent Care Assistance as an optional benefit under the MSECP subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSEDCAP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSECP.

ARTICLE FOUR
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSEDCAP unless the total assistance amount, including all other amounts paid to the participant for Dependent Care Assistance during the same Plan Year, does not exceed the lesser of: (a) five thousand dollars ($5,000) (twenty-five hundred dollars ($2,500) in the case of a married individual filing a separate return), or (b) the wages, salaries and other employee compensation of the participant if unmarried or if the participant is married does not exceed the lesser of such employee compensation of the participant or that of the participant's spouse. For purposes of this paragraph, employee compensation shall not include the total of the permissible amounts selected under the related MSECP. For each month during which a spouse is a full-time student or incapable of independent self-care, said spouse shall be deemed to be gainfully employed and to have employee compensation of two hundred fifty dollars ($250) if there is only one (1) child or dependent and five hundred dollars ($500) if there are two (2) or more children or dependents. A spouse is a student only if during each of five (5) calendar months during the Plan year said spouse is a full-time student at an education organization described in Internal Revenue Code Section 170(b)(1)(A)(ii).

4.02 No payment shall be made from the MSEDCAP, directly or indirectly, for an obligation incurred by a participant during a Plan Year for services provided to the participant by a person who, under Internal Revenue Code Section 151(c), is allowable to the participant or the participant's spouse as a deduction for a personal exemption for the Plan Year, or who is a son, stepson, daughter or stepdaughter of the participant and is under age nineteen (19) at the close of the relevant Plan Year.

4.03 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSEDCAP in excess of the available funds in the individual participant's account. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.

4.04 Claims for payment or reimbursement must be accompanied by invoices or such other reasonable evidence of expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date that the expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source.

ARTICLE FIVE
MISCELLANEOUS

5.01 Reasonable notification of the availability and terms of the MSEDCAP and the related MSECP shall be provided by the employer to all employees.

5.02 On or before each January 31, the employer shall furnish to each participant under the MSEDCAP a statement (form W-2) showing the total amount redirected under the Plan for payment of dependent care expenses incurred by the participant during the previous calendar year.

ARTICLE SIX
AMENDMENT AND TERMINATION

6.01 The employer reserves to itself the right to amend this MSEDCAP in any manner which it deems to be necessary or desirable and shall amend the MSEDCAP in any respect necessary to conform the same to the provisions of the Internal Revenue Code or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSEDCAP by appropriate action.

APPENDIX C
MISSOURI STATE EMPLOYEES' FLEXIBLE MEDICAL BENEFITS PLAN

The State of Missouri hereby establishes for the benefit of its employees a Flexible Medical Benefits Plan (hereinafter called the MSEFMBP) intended to conform to the requirements of Section 105(b) of the Internal Revenue Code and in association with the Missouri State Employees' Cafeteria Plan (Appendix A, hereinafter called the MSECP), established concurrently herewith.

ARTICLE ONE
DEFINITIONS

1.01 "Medical care expense" means expenses incurred by a participant, spouse or dependent for medical care to the extent that the participant or other person incurring the expense is not reimbursed for the expense through any other accident or health plan, as defined in United States Code Section 213(d). Expenses for premiums or contributions made to any other health or accident plan (whether or not maintained by the employer) and long-term care expenses are not considered Medical Care Expenses for the purposes of this Plan.

1.02 "Incurred" means when the participant is provided with the medical care that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the medical care.

1.03 All terms defined in the related MSECP document, whenever used in this MSEFMBP document, shall have the same meaning as required by the definition set forth in said MSECP document.

1.04 "Covered individual" means the participant, the participant's spouse or a dependent of the participant as defined in the MSECP.

1.05 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.

1.06 "PHI" means protected health information.

1.07 "Protected health information" means information that is created or received by MSEFMBP and relates to the past, present, or future physical or mental health or condition of a covered individual; the provision of health care to a covered individual; or the past, present, or future payment for the provision of health care to a covered individual; and that identifies the covered individual or for which there is a reasonable basis to believe the information can be used to identify the covered individual. Protected health information includes information of persons living or deceased.

ARTICLE TWO
STATEMENT OF PURPOSE

2.01 The purpose of this MSEFMBP is to make possible the inclusion of medical expenses in the group of benefits which may be selected by participants of the related MSECP and to satisfy the requirement of a written plan with respect to a medical expenses plan as set forth in the Internal Revenue Code.

ARTICLE THREE
ELIGIBILITY

3.01 Any person who is eligible to participate in the related MSECP is eligible to select Flexible Medical Benefits as an optional benefit under the MSECP subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSEFMBP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSECP.

3.02 Participants who elect to participate in this MSEFMBP shall elect to participate for the full Plan Year. Participants may arrange to have contributions made to the Plan as specified in the MSECP, section 6.01, so long as the participant remains an employee of the employer. Participation and coverage shall cease upon separation of service as of the last day of the month in which the last contribution was received.

3.03 No participant in this MSEFMBP may modify or revoke an election with respect to the Plan Year, except under the conditions specified in MSECP, section 3.09. In no case may a decrease in the amount of election result in a return of contributions to the participant.

ARTICLE FOUR
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 Medical care expenses as defined herein will be eligible for payment from the MSEFMBP to the extent of the permissible amount selected by the participant pursuant to the MSECP, sections 3.04 and 4.01(b). Claims paid by any other accident

or health plan, whether or not maintained by the employer, are not reimbursable under this MSEFMBP.

4.02 Claims for reimbursement of medical care expenses must be submitted to the Plan Administrator and must be accompanied by invoices or such other reasonable evidence of the expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date the medical expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source. In no event shall it be the responsibility of the Plan Administrator or the Office of Administration to make inquiry concerning the accuracy of any such statement or certification. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.

4.03 No payment of medical care expenses shall be made from the MSEFMBP to any participant which is in excess of the amount designated by the participant as the permissible amount defined in the MSECP, section 3.04.

4.04 No payment shall be made for any medical care expense incurred after a participant has ceased being a participant in this MSEFMBP.

4.05 Payments to participants shall be suspended whenever the designated contribution amount is not received by the time the next required payment is due. Payments will resume when the required contribution amounts are paid in full.

ARTICLE FIVE
MISCELLANEOUS

5.01 Reasonable notification of the availability and terms of this MSEFMBP and the related MSECP shall be provided by the employer to all employees.

5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall furnish to each participant under this MSEFMBP a written statement showing the amounts paid for medical expenses claimed by the participant relating to the previous calendar year.

ARTICLE SIX
CONTINUATION COVERAGE

6.01 In accordance with Section 42 United States Code 300bb, and notwithstanding any other provision in the MSEFMBP, a participant or his/her spouse or dependent may be eligible to elect to continue the coverage under the MSEFMBP though the participant's election to receive benefits expired or was terminated, under the following circumstances:
(a) Death of the participant;
(b) Termination (other than for gross misconduct) or reduction of hours of the participant;
(c) Divorce or legal separation of the participant; and
(d) A dependent child ceasing to be a dependent child under the terms of this plan.
The right to continuation coverage shall only be available if on the date of the qualifying event the participant's remaining benefits for the current plan year are greater than the participant's remaining premium payments.

6.02 When the MSEFMBP is notified that one of the events described in section 6.01 has happened, it will in turn notify the eligible person(s) of the right to choose continuation coverage. The election period for continuation coverage begins when coverage would otherwise terminate under the MSEFMBP and ends sixty (60) days after the latter of the date when coverage would otherwise terminate, or the date notice of the right to continue coverage is provided by the Plan Administrator. It is the responsibility of the employee-participant or a responsible family member to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(c) and 6.01(d) above. It is the responsibility of the employer to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(a) and 6.01(b) above.

6.03 A premium may be charged to the participant, spouse or dependent, as the case may be, for any period of continuation coverage equal to not more than one hundred two percent (102%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents. Any additional premium amount in excess of one hundred percent (100%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents, shall not be credited to the participant's account and shall be treated as an additional administrative charge. Continuation coverage will not extend beyond the end of the current plan year. However, coverage may terminate earlier if:
(a) The employer ceases to provide any medical reimbursement plans to any employee;
(b) The premiums described above are not paid within thirty (30) days of their due date; or
(c) A party electing continuation coverage becomes covered under another group health plan or entitled to Medicare benefits.

6.04 Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the MSECP.

6.05 Continuation coverage shall be provided in accordance with the requirements of Section 42 U.S.C. 300bb, all of which requirements are incorporated herein by reference.

ARTICLE SEVEN
FAMILY AND MEDICAL LEAVE

7.01 An employee is entitled to continue coverage under the MSEFMBP during FMLA leave or during a period of duty in the Uniformed Services lasting more than thirty-one (31) days. An employee making premium payments who chooses to continue coverage while on FMLA leave is responsible for the share of premiums that the employee was paying while working.

7.02 An employee who continues coverage while on paid or unpaid FMLA leave may choose from one or both of the following payment options. These options are referred to in this section as pre-pay and pay-as-you-go.
(a) Pre-pay.
(1) Under the pre-pay option, an employee may pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period.
(2) Contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any taxable compensation.
(3) Contributions under the pre-pay option may also be made on an after-tax basis.
(b) Pay-as-you-go.
(1) Under the pay-as-you-go option, employees may pay their premium payments on the same schedule as payments would be made if the employee were not on leave or under any other payment schedule permitted by the Labor Regulations at 29 CFR 825.210(c) (i.e., on the same schedule as payments are made under the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272; under the employer's existing rules for payment by employees on leave without pay; or under any other system voluntarily agreed to between the employer and the employee that is not inconsistent with this section or with 29 CFR 825.210(c)).
(2) Contributions under the pay-as-you-go option may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due the employee during the leave period, and provided that all cafeteria plan requirements are satisfied.
(3) Coverage under the MSEFMBP will be terminated for any employee who fails to make required premium payments while on FMLA leave.

ARTICLE EIGHT
AMENDMENT AND TERMINATION

8.01 The employer reserves to itself the right to amend this MSEFMBP in any manner which it deems to be necessary or desirable and shall amend the MSEFMBP in any respect necessary to conform to the provisions of the Internal Revenue Code, or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSEFMBP by appropriate action.

ARTICLE NINE
PRIVACY POLICY

9.01 The MSEFMBP will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

9.02 Meaning of Payment.
Payment has the meaning specified in the Code of Federal Regulations §164.501, specifically:
(1) The activities undertaken by:
i. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
ii. A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and
(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
i. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
ii. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
iii. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
iv. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
v. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
vi. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
A. Name and address;
B. Date of birth;
C. Social security number;
D. Payment history;
E Account number; and
F. Name and address of the health care provider and/or health plan.

9.03 Meaning of Health Care Operations.
Health care operations has the meaning as specified in the Code of Federal Regulations §164.501, specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

i. Management activities relating to implementation of and compliance with the requirements of this subchapter;

ii. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer;

iii. Resolution of internal grievances;

iv. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

v. Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

9.04 As required by law and authorization.
The MSEFMBP will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the MSEFMBP will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.

9.05 Disclosures to the Employer.
The MSEFMBP will disclose PHI to the Employer as sponsor of the MSEFMBP provided that the Employer agrees to:

(1) Not use or further disclose PHI other than as permitted or required by this MSEFMBP document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the MSEFMBP agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

(4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;

(5) Report to the MSEFMBP any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available to an individual in accordance with HIPAA's access requirements;

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(8) Make available the information required to provide an accounting of disclosures;

(9) Make internal practices, books and records relating to the use and disclosure of PHI received from the MSEFMBP available to the Secretary of Health and Human Services for the purposes of determining the MSEFMBP's compliance with HIPAA; and

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

9.06 Employees with access to PHI.
In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose of performing Employer Plan administrations functions:

(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer;

(2) Any employee with oversight responsibility for management of the MSEFMBP or any component of the MSEFMBP.

If the above employees do not comply with this MSEFMBP document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.

9.07 HIPAA Compliance.
It is intended that this MSEFMBP meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued thereunder. This MSEFMBP shall be construed, operated and administered accordingly,

and in the event of any conflict between any part, clause or provision of this MSEFMBP and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this MSEFMBP shall be deemed superseded to the extent of the conflict.]

APPENDIX A
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN DOCUMENT

Cafeteria Plan
for the Employees of
the State of Missouri

Plan Document

Effective January 1, 2011
(with an original effective date of January 1, 1992)

Cafeteria Plan
for the Employees of
the State of Missouri

Plan Document

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Section 1
Introduction

1.1 Establishment of the Plan

The State of Missouri (the "Employer") hereby amends the State of Missouri Cafeteria Plan (the "Plan") effective January 1, 2011 (the "Effective Date"). The original Plan was effective January 1, 1992.

1.2 Purpose of the Plan

This Plan allows an Employee to participate in the following Benefit Options:

- Premium Payment Plan (PPP) to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or contribution for the Health Plan.
- Health Flexible Spending Account (Health FSA) to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- Dependent Care Assistance Program (DCAP) to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.
- Health Savings Account Contribution Benefit (HSA Contribution Benefit) to make pre-tax Salary Reduction Contributions to a Health Savings Account.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under the Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA is intended to qualify as a self-insured health reimbursement plan under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

The DCAP is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

The HSA Contribution Benefit is intended to meet all requirements of §223 of the Code.

Although reprinted within this document, the Health FSA, the DCAP and the HSA Contribution Benefit are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health FSA is also a separate plan for purposes of applicable provisions of COBRA and HIPAA.

1.4 Capitalized Terms

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other

relevant Sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.

Section 2
General Information

Name of the Cafeteria Plan	State of Missouri Cafeteria Plan
Name of Employer	State of Missouri
Address of Plan	Office of Administration, P.O. Box 809, Jefferson City, MO 65102-0809
Plan Administrator	State of Missouri/Office of Administration
Plan Sponsor and its IRS	State of Missouri/Office of Administration
Employer Identification Number	44-6000987
Named Fiduciary & Agent for Service of Legal Process	State of Missouri
Type of Administration	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Missouri Cafeteria Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. State of Missouri may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
Plan Number	501
Benefit Option Year	The twelve-month period ending December 31.
Plan Effective Date	January 1, 2011, with an original effective date of January 1, 1992
Claims Administrator	Application Software, Inc., dba ASI, dba ASIFlex
Plan Renewal Date	January 1
Internal Revenue Code and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section -- Section 2.

Section 3
Benefit Options and Method of Funding

3.1 Benefits Offered

Each Employee may elect to participate in one or more of the following Benefits:

- Premium Payment Plan (PPP) as described in Schedule A.
- Health Flexible Spending Account (Health FSA) as described in Schedule B.
- Health Savings Account Contribution Benefit (HSA Contribution Benefit) as described in Schedule C.
- Dependent Care Assistance Program (DCAP) as described in Schedule D.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

3.2 Employer and Participant Contributions

- Employer Contributions. The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the PPP under this Plan; however, if the Participant elects the PPP as described in Schedule A, the Employer may contribute toward the Health Plan as provided in the respective plan or policy of the Employer.
- Participant Contributions. The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.3 Computing Salary Reduction Contributions

- Salary Reductions per Pay Period. The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a semi-monthly or monthly basis in the Period of Coverage;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- Salary Reductions Following a Change of Elections. If the Participant changes his or her election under the PPP, Health FSA, or DCAP, as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
  - An amount equal to:

        - The new annual amount elected pursuant to the Method of Timing and Elections section below;
        - Less the aggregate Contributions, if any, for the period prior to such election change;
        - Payable over the remaining term of the Period of Coverage commencing with the election change;
    - An amount otherwise agreed upon between the Employer and the Participant; or
    - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- Salary Reductions Considered Employer Contributions for Certain Purposes. Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.

- Salary Reduction Balance Upon Termination of Coverage. If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

- After-Tax Contributions for PPP. After-tax Contributions for the Health Plan will be paid outside of this Plan.

3.4 Funding This Plan

- Benefits Paid from General Assets. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.

- Participant Bookkeeping Account. While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.

- Maximum Contributions. The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the PPP as described in

Schedule A, Health FSA as described in Schedule B, HSA Contribution Benefit as described in Schedule C and the DCAP as described in Schedule D.

Section 4
Eligibility and Participation

4.1 Eligibility to Participate

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in the Glossary.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

4.2 Required Salary Reduction Agreement

To participate in the Health FSA or DCAP, an Employee must complete, sign and return to the Plan Administrator a Salary Reduction Agreement by the deadline designated by the Plan Administrator. If an Employee fails to return a Salary Reduction Agreement, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

4.3 Termination of Participation

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits. In addition, an Employee filing a false or fraudulent claim is subject to disciplinary action, up to and including termination of employment.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof.

4.4 Rehired Employees

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 30 days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination. If the Employer rehires a former Participant within the same Plan Year but more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

4.5 Eligibility Rules Regarding the Health FSA

An Employee enrolled in a Health Savings Account (HSA) is not eligible to enroll in the Health FSA.

4.6 Eligibility Rules Regarding the HSA Contribution Benefit

An Employee must be an HSA Employee to elect to participate in the HSA Contribution Benefit Plan.

Only Employees who satisfy the following conditions may be considered an HSA Employee:

- Covered under a qualifying High Deductible Health Plan (HDHP) maintained by the Employer;
- Opened an HSA with the custodian chosen by the Employer;
- Not covered under any other non-HDHP maintained by one Employer that is determined by the Employer to offer disqualifying health coverage;
- Not claimed as a tax dependent by anyone else;
- Not enrolled in Medicare coverage; and
- Eligible to participate in the Plan.

4.7 FMLA Leaves Of Absence

Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer's designee by the due date established by the Employer;

- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any; or

- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

4.8 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax Contributions while on leave or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.9 Death

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the date of death. A Participant may designate a

specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

4.10 **COBRA**

Under the COBRA rules, as discussed in the attached Schedules B and C, where applicable, the Participant's Spouse and Dependents may be able to continue to participant under the Health FSA through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

4.11 **USERRA**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

Section 5
Method of Timing and Elections

5.1 Initial Election

An Employee must complete, sign and return a Salary Reduction Agreement within the election-period set forth therein to enroll in the Benefit Options, other than the PPP.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the 1st day of the month coinciding with or after the date the Employee completes, signs and returns a Salary Reduction Agreement or completes a Salary Reduction Agreement using the electronic system produced by the Employer (if any), within the election period set forth therein.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option (see Glossary for definition). The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

5.2 Open Enrollment

During each Open Enrollment Period, the Plan Administrator shall make available a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete sign and return the Salary Reduction Agreement or complete an election using the electronic system provided by the Employer, if any, to the Plan Administrator on or before the last day of the Open Enrollment Period. There is an exception of automatic elections in the PPP.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

The Employer may, in lieu of a Salary Reduction Agreement, provide an electronic method for Employees to use to make elections. The Employer may require Employees to use the electronic system to make elections. Use of an electronic system will have the same effect as a signed Salary Reduction Agreement.

5.3 Failure To Elect

If an Employee fails to complete, sign and return a Salary Reduction Agreement or fails to complete an election using the electronic system (if any) provided by the Employer within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash (excluding the PPP). The Employer provides for an automatic election for the PPP, therefore, the Employee will have also agreed to a Salary Reduction for such Employee's Contribution to the PPP.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

- **Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.**

Section 6
Irrevocability of Elections and Exceptions

6.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

The irrevocability rules do not apply to the HSA Contribution Benefit election.

The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance.

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

- Timing for Making New Election if Exception to Irrevocability Applies. A Participant may make a new election within 30 days of the occurrence of an event described in section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.

- Effective Date of New Election. Elections made pursuant to this Section shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.

- Changes. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document.

- Effect on Maximum Benefits. Any change in an election affecting annual Contributions to the Health FSA or DCAP also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

  - Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to

  - The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by

  - All reimbursements made during the entire Period of Coverage.

6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- Legal Marital Status. A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the DCAP, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);
- Employment Status. Any of the following events that change the employment status of the Participant, Spouse or Dependents:
    - A termination or commencement of employment;
    - A commencement of or return from an unpaid leave of absence;
    - A change in worksite; or
    - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;
- Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and
- Change in Residence. A change in the place of residence of the Participant, Spouse or Dependent(s).

6.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- Open Enrollment Period. A Participant may change an election during the Open Enrollment Period.

- Termination of Employment. A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.

- Leave of Absence. A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.

- Change in Status. *(Applies to the PPP, Health FSA, and DCAP as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

  A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

  The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

  - Loss of Spouse or Dependent Eligibility. For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel health plan coverage and deduction plans offered under the Voluntary Payroll Vendors for:

    - The Spouse involved in the divorce, annulment, or legal separation;

    - The deceased Spouse or Dependent; or

    - The Dependent that ceased to satisfy the eligibility requirements.

    Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

    Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

  - Gain of Coverage Eligibility Under Another Employer's Plan. When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has