Rules of
Office of Administration
Division 10—Commissioner of Administration
Chapter 15—Cafeteria Plan

Title 1—OFFICE OF ADMINISTRATION

Division 10—Commissioner of Administration

Chapter 15—Cafeteria Plan

1 CSR 10-15.010 Cafeteria Plan

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

(1) The cafeteria plan for state employees, authorized by section 33.103, RSMo shall contain the following items:

(A) A provision authorizing the payment through the cafeteria plan of a participating employee'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 his/her status as an employee;

(B) A provision authorizing the payment through the cafeteria plan, pursuant to a separate but related flexible medical benefits plan, established in conjunction with the cafeteria plan, of amounts expended by a participating employee for medical care of the employee or spouse or dependent, which amounts are not covered or reimbursable to the employee from any other source;

(C) A provision authorizing the payment or reimbursement through the cafeteria plan of employment-related expenses for the care of a spouse or dependent of a participating employee, pursuant to a separate but related dependent care assistance plan of the state, established concurrently with the cafeteria plan;

(D) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any plan or program of group term life insurance covering the employee's life, which plan or program is available to the employee by reason of his/her status as an employee;

(E) A provision authorizing the payment through the cafeteria plan of a participating employee'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 his/her status as an employee;

(F) A provision authorizing the payment through the cafeteria plan of a participating employee'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 his/her status as an employee; and

(G) A provision authorizing a participating employee to reduce his/her future compensation for purposes of participation in the cafeteria plan.

(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 incorporated in this rule by reference, for Plan Year 1998 and years following.

AUTHORITY: section 33.103, RSMo Supp. 1999. Original rule filed March 15, 1988, effective June 1, 1988. Emergency amendment filed Dec. 13, 1989, effective Dec. 23, 1989, expired April 21, 1989. Amended: Filed Dec. 13, 1989, effective Feb. 25, 1990. Amended: Filed May 15, 1990, effective Sept. 28, 1990. Emergency amendment filed Dec. 4, 1990, effective Jan. 1, 1991, expired April 29, 1991. Amended: Filed Dec. 4, 1990, effective April 29, 1991. Emergency amendment filed Oct. 2, 1991, effective Jan. 1, 1992, expired April 29, 1992. Amended: Filed Oct. 2, 1991, effective Feb. 6, 1992. Emergency amendment filed Aug. 25, 1992, effective Jan. 1, 1993, expired April 30, 1993. Amended: Filed April 25, 1992, effective April 8, 1993. Amended: Filed Aug. 1, 1997, effective Jan. 1, 1998. Emergency amendment filed Dec. 14, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 14, 1998, effective June 30, 1999. Emergency amendment filed Dec. 15, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Sept. 15, 1999, effective March 30, 2000.*

**Original authority: 33.103, RSMo 1951, amended 1969, 1975, 1977, 1987, 1989, 1990, 1993, 1997, 1998, 1999.*

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, 2000. The MSECP shall be in the form of a trust established by the State of Missouri for public employees of the state who participate in the MSECP. 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 who elects to participate in the MSECP beginning with Plan Year 2000.

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 benefit 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.

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

1.05 "Participant" means any employee who has elected to 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 Cod*e of 1986.

ARTICLE TWO
STATEMENT OF PURPOSE

2.01 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, 2000) 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 at the beginning of each Plan Year. Any eligible 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, unless the employee experiences a change in family status as provided under the MSECP, section 3.07, whereby the employee may enroll within sixty (60) days of the occurrence of the allowable change in family status.

3.03 Any person who becomes an employee after the effective date shall be eligible for enrollment in the MSECP for one hundred twenty (120) 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 Plan Administrator's receipt of the employee's enrollment application.

3.04 Subject to the provisions of the MSECP, section 3.05, an eligible employee shall become a participant for any Plan Year by specifying on the appropriate election form or in an alternate prescribed manner, agreement to and authorization for 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 for coverage not to exceed applicable Internal Revenue Service limits in the case of the State-Sponsored Group Term Life 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 Dental Insurance benefit described in the MSECP, section 4.01(e);

(f) 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(f); and

(g) not more than the total of maximum amounts set forth previously in the case of the benefit described in the 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 described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e) and 4.01(f), the permissible amount elected by the employee must be consistent with or 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 authorization required by the provision of the MSECP section 3.04 must be submitted to the Plan Administrator 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 authorization with the Plan Administrator no later than one hundred twenty (120) days from the date of employment.

3.06 Beginning with Plan Year 1999, any employee duly enrolled and participating in one or more of the insurance benefits described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e) or 4.01(f), shall be considered to have re-enrolled and to have submitted the required authorization to continue participation in the same benefit(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 benefit 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.

3.07 Permitted Election Changes.

(a) Following the commencement of any Plan Year for which an employee elects to participate 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 (i) of this section.

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

(c) Changes in status for benefits described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), and 4.01(f).

1. An employee may revoke an election for a benefit described under Article Four, section 4.01(a), 4.01(d), 4.01(e), or 4.01(f) and make a new election for the remaining portion of the period if, under the facts and circumstances—

(i) Following the commencement of any Plan Year a change in status occurs; and

(ii) The election change satisfies the consistency requirement in paragraph (c)(3) of this section (consistency rule for accident or health coverage), (c)(4) of this section (consistency rule for Flexible Medical Benefits) or (c)(5) of this section (consistency rule for group-term life insurance coverage).

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;

(iii) Employment status. A termination or commencement of employment by the employee, spouse, or dependent;

(iv) Work schedule. A reduction or increase in hours of employment by the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence;

(v) 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

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

3. Consistency rule for accident or health coverage—

(i) General rule.

(A) An employee's revocation of a Cafeteria Plan election during a period of coverage and 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—

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

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

(B) 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 benefit 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.

(ii) Exception for COBRA. Notwithstanding paragraph (c)(3)(i) of this section, if the employee, spouse, or dependent becomes eligible for continuation coverage under the employer's group health plan as provided in section 4980B or any similar state law, the employee may elect to increase payments under the Cafeteria Plan in order to pay for the continuation coverage.

4. Consistency rule for flexible medical benefits. 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) 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, or the commencement of a leave under the Family and Medical Leave Act.

5. Consistency rule for group-term life insurance coverage. Except as provided in this paragraph (c)(5), the provisions of paragraph (c)(3)(i) of this section apply to group-term life insurance coverage. In the case of marriage, birth, adoption, or placement for adoption, an employee may make an election change to increase (but not to reduce) the amount of the employee's life insurance coverage. In the case of divorce, legal separation, annulment, or death of a spouse or dependent, an employee may make an election change to reduce (but not to increase) the amount of the employee's life insurance coverage.

(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 benefit described under sections 4.01(a), 4.01(b), 4.01(e), or 4.01(f) to provide coverage for the child if the order requires coverage under the employee's plan; or

2. Make an election change to a benefit described under sections 4.01(a), 4.01(e), or 4.01(f) 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 benefit described under sections 4.01(a), 4.01(e), or 4.01(f) to cancel coverage of that employee, spouse, or dependent under the accident or health plan.

(f) Election Changes for Dependent Care. An employee may revoke an election for a benefit described under Article Four, section 4.01(c) and make a new election for the remaining portion of the period if, under the facts and circumstances a change in status occurs; and the revocation and new election are consistent with and on account of the change in status. Examples of changes in status are:

1. Legal martial status. Events that change an employee's legal martial status, including marriage, death of spouse, divorce, legal separation, or annulment;

2. Number of dependents. Events that change an employee's number of dependents (as defined in section 152), including birth, adoption, placement for adoption (as defined in regulations under section 9801), or death of a dependent; or

3. Employment status. A termination or commencement of employment by the employee or spouse or the commencement of or a return from an unpaid leave of absence.

(g) Significant coverage or cost changes.

1. Employer's plan. A participant's election for a benefit described under Article 4.01(a), 4.01(e), or 4.01(f) will automatically be changed to reflect a change in the cost of coverage attributable to an independent third party provider. Alternatively, if the premium amount significantly increases or coverage is significantly curtailed 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. A participant may revoke an existing election for a benefit described in section 4.01(a), 4.01(e), or 4.01(f) and make a new election due to a significant change in the health coverage of the participant or the participant's spouse attributable to the spouse's employment. A participant may increase an existing election for a benefit described in section 4.01(b) due to a significant change in the health coverage of the participant or the participant's spouse attributable to the spouse's employment. Any change must be consistent with and on account of the change in health coverage attributable to the spouse's employment.

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

An employee taking FMLA leave may revoke an existing election of a benefit described under 4.01(a), 4.01(b), 4.01(e), or 4.01(f) 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 (e.g., because of changes in status or significant cost or coverage changes imposed by a third-party provider) 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 3.07), prorated for the period during the FMLA leave for which no premiums were paid, and reduced by prior reimbursements.

An employee on FMLA leave has the right to revoke or change elections (e.g., because of changes in family status) under the same terms and conditions that apply to employees participating in the Cafeteria Plan who are not on FMLA leave.

(i) 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(f) shall be effective with the first required premium payment after the event. Any provider initiated increase in the premium for a program described in the Plan document under Article Four, section 4.01(d) may be added to the participant's election amount only during the first month that the premium increase becomes effective and only to the extent as allowed under applicable Internal Revenue Service regulations.

ARTICLE FOUR
AVAILABLE SELECTION OF BENEFITS

4.01 In general, employees may choose to participate in any one or more of the following benefit categories offered under the MSECP:

(a) State-Sponsored Medical Insurance—This benefit 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), or is obtained by competitive bid and is not duplicative of any other plan provided by the MCHCP. 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 benefit 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 benefit 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 Group Term Life Insurance—This benefit category provides for the direct payment to the insurance provider for the participant's share of the cost or premium for coverage under any plan or program which provides group term life insurance covering the participant's life, which plan or program is available to the employee by reason of status as an employee;

(e) State-Sponsored Dental Insurance—This benefit 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 and is not duplicative of any other plan provided by the MCHCP;

(f) State-Sponsored Vision Care Insurance—This benefit 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 and is not duplicative of any other plan provided by the MCHCP; and

(g) Cash.

ARTICLE FIVE
GENERAL PROVISIONS REGARDING BENEFITS

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 benefit election 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 effective date of enrollment through the end of the Plan Year. 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 3.02, 4.04, 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 benefits 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 benefit 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.

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 MSECP.

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.

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* of 1986, 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 ($5000) (twenty-five hundred dollars ($2500) 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 dollars ($200) if there is only one (1) child or dependent and four hundred dollars ($400) if there are two (2) or more children or dependents. A spouse is a student only if during each 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* of 1986 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* of 1986 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 any health-related expenditure which meets the criteria as a deductible medical expense under Section 213 of the *Internal Revenue Code* (disregarding the 7.5% exclusion) with the specific exception of premiums or contributions made to any other health or accident plan (whether or not maintained by the employer), and long-term care expenses.

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.

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. Upon termination of employment with the employer, payment of claims shall cease if required contributions are not received by the date the next required contribution is due.

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 307. In addition, no participant may decrease the amount elected during a Plan Year except for a change due to the death of a spouse or dependent of the participant, divorce or legal separation, or for the participant taking a FMLA leave. 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 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 contin-

uation 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 employer;

(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.

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 FMLA leave may choose from one or more of the following payment options. These options are referred to in this section as pre-pay, pay-as-you-go and catch-up. The catch-up option is only available while the employee is on an unpaid FMLA leave.

(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 a benefit described in section 4.01(b) will be terminated for any employee who fails to make required premium payments while on FMLA leave.

(c) Catch-up.

(1) An employee on an unpaid FMLA leave may elect to use the catch-up option to pay premiums advanced on his or her behalf by the state during the FMLA leave. The state and the employee must agree in advance of the coverage period that: the employee elects to continue coverage while on unpaid FMLA leave; the state will assume responsibility for advancing payment of the premiums on the employee's behalf during the FMLA leave; and these advance amounts must be paid by the employee when the employee returns from FMLA leave.

(2) Contributions under the catch-up option may be made on a pre-tax salary reduction basis when the employee returns from FMLA leave from any available taxable compensation. These contributions will not be included in the employee's gross income, provided that all Cafeteria Plan requirements are satisfied.

(3) Contributions under the catch-up option may also be made on an after-tax basis.

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* of 1986, or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSEFMBP by appropriate action.