
**MILLICAN & ASSOCIATES
EMPLOYEE'S CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION**

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PART I. GENERAL INFORMATION ABOUT THE EMPLOYEE'S CAFETERIA PLAN

Q-1. What is the purpose of the Plan ?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction, to choose one or more of the Benefit Plans or Policies offered through the Plan, and enable them to pay for the selected coverage(s) with pre-tax dollars.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan ?

Under the Plan, you may elect certain Core Benefits, as described below, which you may be required to make a contribution. You may be entitled to make your contribution on a pre-tax and after-tax basis to pay for coverage(s). In addition, you may elect Non-Core Benefits, as described in Appendix A and Appendix B, and depending on the benefit, you may be entitled to use your earnings on a pre-tax basis and after-tax basis to pay for coverage under such Non-Core Benefits.

The benefits offered under this Plan *may* include one or more of the following:

- Dependent Care Expense Account
- Health Care Expense Account
- Group Health Insurance
- Group Dental Insurance
- Group Term Life Insurance
- Vision Insurance
- Accidental Death and Dismemberment (AD & D) Insurance
- Personal Cancer Indemnity Plan
- Personal Hospital Intensive Care Plan
- Voluntary Hospital Indemnity Plan
- Personal Short-Term Disability Plan
- Personal Accident Indemnity Plan
- Personal Sickness Indemnity Plan

The benefits available under the Plans are more fully described below and in Appendix B attached in the enrollment materials that you will be given.

The Plan allows you to purchase certain of the Non-Core Benefits on a pre-tax basis by authorizing the Employer to withhold such amounts from your salary or wages prior to consideration of certain taxes. The amount you authorize to be withheld from your earnings on a pre-tax basis (Pre-Tax Benefit Dollars) will not count as taxable income for federal or Social Security tax purposes.

The rules regarding the taxation of amounts withheld from your salary or wages for federal, state or local income tax purposes are all subject to change.

The Flexible Benefits Plan, the Dependent Care Expense Account Plan and the Health Care Expense Account Plan are interrelated in that a Dependent Care Expense Account and a Health Care Expense Account have been established under the Flexible Benefits Plan in order to record contributions to and reimbursements from the Dependent Care Expense Account Plan and the Health Care Expense Account Plan. The Dependent Care Expense Account Plan is intended to qualify under section 129 of the Code, and the Health Care Expense Account Plan is intended to qualify under section 105 of the Code, so that the value of the benefits you elect to receive may be excluded from your taxable compensation.

The Plans are established for the exclusive benefit of participants, their covered dependents, and their beneficiaries, and are administered impartially for the benefit of all eligible employees.

The various benefit options available will be described to you in information materials distributed prior to each enrollment period. For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each of the above programs. Ask the Plan Administrator for copies.

Q-3. Who can participate in the Plan ?

Employees who regularly and consistently work 25 or more hours per week of the Employer (other than employees covered under a collective bargaining agreement) are eligible to participate in the Plan upon becoming eligible for any of the contributory health (and other) insurance benefits included below. "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as an independent contractor, or as a temporary or casual employee, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly", "Manpower", etc., or any employee covered under a collective bargaining agreement.

Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until he or she: i) elects not to participate in accordance with Q-7; or ii) is no longer employed by the Employer, or Continuation Coverage (as described below) is no longer in effect.

Q-4 What tax advantages are available through the Plan ?

Suppose your monthly gross pay is \$ 2,500 per month and your cost for coverage is \$ 140.00 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$ 1,794.00. However, under the Pre-Tax Premium plan, you will be considered to have received \$ 2,360.00 gross pay rather than \$ 2,500 for tax purposes with \$ 140.00 contributed for medical coverage. This means your take home pay will be \$ 1,825.00 with the Pre-Tax Premium plan rather than \$ 1,794.00 without it. Thus, you save \$ 31.00 per month (\$ 372.00 per year) by participating in the Pre-Tax Premium plan. The Table below illustrates this savings:

	With Flexible Benefits Plan	Without Flexible Benefits Plan
Gross Monthly Pay	\$ 2,500.00	\$ 2,500.00
Pre-Tax Coverage Under the Plan	140.00	---
Taxable Income	<u>2,360.00</u>	<u>2,500.00</u>
Estimated Federal Tax (15%)	354.00	375.00
FICA Tax (7.65%)	181.00	191.00
After-Tax Coverage	---	<u>140.00</u>
Take Home Pay	<u>\$ 1,825.00</u>	\$ 1,794.00

Q-5. How do I become a participant ?

In any Plan Year, you will be entitled to choose benefits listed as Core Benefits described in Appendix A, if offered by the Employer. In addition, you may elect coverage under certain Non-Core Benefits described in Appendix B. You will pay for coverage under such Non-Core Benefits in the form of Pre-Tax or After-Tax Benefit Dollars unless provided otherwise in Appendix B. The enrollment form you complete identifies your benefit elections and authorizes the Company to withhold an amount from your salary or wages equal to your Employee Premium Share, if any, and the cost of certain Non-Core Benefits elected by you. If you fail to make a benefit election or complete the enrollment form with respect to the first Plan Year, you may forfeit Core Benefits, if provided, and Non-Core Benefits for such Plan Year. Your level of coverage will be consistent with your family status reported on Company records.

You must make your elections with respect to a Plan Year during the Open Enrollment Period immediately preceding such Plan Year. After-Tax and Pre-Tax Benefit Dollars used to purchase benefits under the Plans shall be deducted from your paychecks in substantially equal amounts throughout the Plan Year. Upon your termination of employment with the Company, deductions of After-Tax and Pre-Tax Benefit Dollars will cease.

The benefits offered under the Plans may be changed from time to time at the sole discretion of the Company. The benefits currently offered under the Plans are described in Appendix B to this summary plan description. In the event of any changes in such benefits, you will be notified by the Plan Administrator and provided with an amended Appendix B identifying such changes.

In future years, a new Salary Reduction Agreement will be made available to you by the first day of the Annual Open Enrollment Period, and you will be given the opportunity to confirm or change your choices made for the previous 12-month period for the coming 12 months beginning on the first day of the next Plan Year.

A Participant who fails to complete, sign and file a Salary Reduction (Redirection) Agreement as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and (except for a Change in Status) will not be permitted to modify his election until the next Annual Open Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical and Dependent Care Expense Account Plans must be made by submitting a salary reduction agreement prior to the beginning of each plan year--no deemed elections shall occur with respect to such benefits.

Your benefit choices shall become effective in the Plan Year for which the election is made, as of the first pay period of the new Plan Year.

Q-6. What are the enrollment periods for entering the Plan ?

The Enrollment Period will generally begin at least 30 days before the Anniversary Date and end on the Anniversary Date.

Q-7. Can I change my election during the Plan Year ?

Generally, you cannot change your election to participate in the Pre-Tax Election option or vary the Pre-Tax Elections you have selected, during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections for Pre-Tax Elections only during the Annual Open Enrollment Period, and then, only for the coming Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election for Pre-Tax deductions during the Plan Year if you file a written request for change with the Plan Administrator within 30 days of any of the following events:

1. Change in Status. If there are one or more of the following Changes in Status, you may revoke your old election and make a new election, provided that both the revocation and new election are caused by and are consistent with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below and any other events that the Plan Administrator (in its sole discretion) determines to be within prevailing IRS guidance:

- a change in your legal marital status (such as marriage, divorce or death of your Spouse)
- a change in the number of your Dependents (such as birth or adoption of a child, or death of a Dependent)
- termination or commencement of employment by you, your Spouse, or your Dependent
- a change in your, your Spouse's or your Dependent's work hours (including a switch between full and part-time status)

- your Dependent satisfying or ceasing to satisfy an eligibility requirement for a particular benefit
- a change in your, your Spouse's or your Dependent's place of residence or work

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Premiums within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and *consistent with* a change in status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and consistent with a Change in Status.

Examples of Permissible Changes:

- For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, disability coverage and Health Care Expense Reimbursement benefits), you may change your election only if the Change in Status results in you, your Spouse or your Dependent becoming eligible or becoming ineligible for the benefit (or particular benefit option) under the Plan (or your Spouse or Dependent's plan) and the election change corresponds with the gain or loss of coverage. However, if you, your Spouse, or a Dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.
- For group term life insurance benefits, if you get married or if a child is born or adopted (or placed for adoption), you may elect to increase life insurance coverage, but not decrease it. If you are divorced, legally separated, or if your Spouse or Dependent dies, you may elect to decrease life insurance coverage, but not increase it.
- For Dependent Care Expense Reimbursement benefits you may change your election only if the Plan Administrator determines in its sole discretion that the change is consistent with the Change in Status.

2. Special Enrollment Rights. If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

3. Certain Judgments and Orders. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child to be covered under this Plan or your former spouse's plan, if the order requires you to cover the child, you may change your election to provide coverage for the child. If the order requires that your former spouse cover the child, you may change your election to revoke coverage for the child.

4. Entitlement to Medicare or Medicaid. If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage.

5. Significant Changes in Cost or Coverage. If an independent, third-party provider of medical benefits significantly increases premiums or significantly curtails coverage, you may revoke your prior election and elect coverage under another health option with similar coverage, provided that you notify the Plan Administrator within 30 days of receiving written notice of the change.

6. Changes in Coverage Attributable to Spouse's Employment. If there is a significant change in your or your Spouse's health coverage which is attributable to your Spouse's employment, you may change your election under the Plan provided that the change is consistent with the change in coverage.

Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law and adjustments may also be made to reflect insignificant mid-year premium increases imposed by third-party insurers.

Q-8. How are my Premium Payments Made ?

When you become a Participant, your premiums will be paid with that portion of gross income that you have elected to forego through pre-tax salary.

Q-9. What if I terminate my employment during the Plan Year ?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See the insurance booklets for information on your right to continued or converted coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

Q-10. Will I have any administrative costs under the Plan ?

The Employer is currently bearing the entire cost of administering the Plan.

Q-11. How long will the Plan remain in effect ?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-12. What happens if a claim for benefits is denied ?

If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedure applicable under the component Benefit Plan or Policy. However, if you are denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under this Plan (i.e. such as a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Flexible Benefits Plan Document), the claims procedure under this Plan will apply, and you will be notified in writing by the Plan's Administrator within 90 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

Q-13. What is "Continuation Coverage" and how does it work ?

"Continuation Coverage" means your right, or your spouse or dependents' right, to continue to be covered under any of the component medical benefit plans if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event". A Qualifying Event is:

- termination of your employment (other than be reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your spouse;
- your becoming entitled to receive Medicare benefits;
- when a dependent of yours ceases to be a dependent.

For a Qualifying Event, other than a change in your employment status, it will be your obligation to inform the appropriate Plan Administrator of each medical benefit plan you have elected of its occurrence within 60 days of the occurrence. The appropriate Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverages provided at stated premium costs with respect to each health plan in which you are a participant. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

Certain Medical Care Expense Reimbursement Expense Account Participants will be eligible for COBRA Continuation Coverage if they have a positive Medical Care Expense Reimbursement Account balance at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the qualifying event occurs, COBRA coverage for the Medical Expense Reimbursement Account will cease at the end of the year and cannot be continued for the next plan year.

Q-14. What effect will Plan participation have on Social Security and other benefits ?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in your Social Security benefits and/or other benefits (e.g. pension, disability and life insurance) which are based on taxable compensation.

PART II. MEDICAL CARE EXPENSE REIMBURSEMENT BENEFITS

You will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Expense Reimbursement Plan. Under this Plan, you make an election for your unreimbursed medical, dental and vision expenses that you reasonably expect to incur during the Plan Year. Then you have that amount deducted from your gross wages -- before taxes -- in lieu of a corresponding amount of current taxable pay. This arrangement helps you because the level of coverage you elect is nontaxable, and you save social security and income taxes on the amount of your annual election for these expenses.

QUESTIONS & ANSWERS

Q-1. Who can participate in the Plan ?

Each employee who is not covered by a collective bargaining agreement, and is eligible to participate in the related Flexible Benefits Plan.

Q-2. How do I become a Participant ?

By electing Medical Care Expense Reimbursement benefits during the Initial or Annual Enrollment Periods.

Q-3. What is my "Medical Care Expense Reimbursement Account" ?

If you elect benefits under this portion of the Plan, a non-interest bearing Medical Care Expense Reimbursement Account ("Account" or "Health FSA") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year.

Q-4. What annual benefits are available under the Medical Care Expense Reimbursement Plan, and how much will they cost ?

You may choose any amount of Plan Year reimbursement you desire up to an annual maximum of \$ 5,000.00. You will be required to pay the annual premium equal to the coverage level you have chosen.

Q-5. How is my Medical Care Expense Reimbursement benefit paid for ?

When you complete the Salary Redirection Agreement, you specify the amount of Medical Care Expense Reimbursement you wish to pay for with your salary reduction. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium deducted from each paycheck. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket medical, dental, and vision expenses at any time during the Plan Year, so long as you continue to pay the premiums. Certain expenses will be subject to a schedule of Per Occurrence Limitations.

For example, suppose you have elected to be reimbursed for up to \$ 1,000 per year for Eligible Medical Expenses, and you have chosen no other benefits under the Flexible Benefits Plan. Your Account would be credited (and funded) with a total of \$ 1,000 during the Plan Year. If you are paid bi-weekly, your Account would reflect that you have paid \$ 38.46 per pay period in premiums for the benefit you have elected.

Q-6. What amounts will be available for Medical Care Expense Reimbursement at any particular time during the Plan Year ?

Provided that you have continued to pay the periodic premiums due for this benefit, the full, annual amount of coverage you have elected will be available at any time during the Plan Year, reduced however by the amount of prior reimbursements received during the Year. Certain expenses may be subject to a schedule of "per occurrence limitations" as determined by your Employer.

Q-7. How do I receive reimbursement under the Plan ?

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. You must include written statement(s) or bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with the Claim Form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) which you are obligated to pay. An expense is considered "*incurred*" when the medical service is provided, not when the service is billed by the provider or actually paid for by the Participant.

If you have paid the premiums for the coverage you have elected, you will be reimbursed for your Eligible Expenses within five (5) days after submitting your claim. Remember, though, you can't be reimbursed for any total expenses above the annual reimbursement amount you have elected. In order to be reimbursed for your Medical Expenses, you must submit your Claim Form by mail or fax to the Plan Administrator no later than 2 ½ months after the end of each Plan Year. You will be notified in writing if any claims for benefits is denied.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is *not* necessary that you have actually paid an amount due for an Eligible Medical Expense -- only that you have **incurred** the expense, and that it is not being paid for or reimbursed from any other source. An expense is "**incurred**" when the medical service is provided, not billed for by the provider or paid by the Participant.

Q-8. What is an "Eligible Expense" ?

An "Eligible Expense" means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return (without regard to any threshold limitation) for which you have not otherwise been reimbursed from insurance, or some other source. Expenses must be for "Medical Care" as defined in IRS Code Section 213(d). Premiums for accident or health insurance coverage under any other plan are **NOT** Eligible Medical Expenses. Also, expenses for long-term care services are not eligible.

You are encouraged to consult your personal tax advisor or IRS Section 213(d) "eligible medical care expenses" for further guidance as to what is or is not an eligible expense if you have any doubts. ***Medical care expenses are defined as: "amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body".***

Q-9. When must the expenses be incurred that I may be reimbursed for ?

Eligible Expenses must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your Salary Redirection Agreement becomes effective, or for any expenses incurred after the close of the Plan Year, except during the "Temporary Carry-Over Period" of 2 ½ months following the end of each Plan Year; or Continuation of Coverage (COBRA) after a separation from service.

Q-10. What if the medical expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Care Expense Reimbursement ?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual medical expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the sixtieth (60th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-11. Forfeiture of Unclaimed Reimbursement Account Benefits.

Any Reimbursement Account benefit payments that are unclaimed (e.g. uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health Care Expense was incurred shall be forfeited.

PART III. DEPENDENT CARE EXPENSE REIMBURSEMENT BENEFITS

You may elect to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Expense Reimbursement Plan ("DCR"). Under these provisions, you provide a source of pre-tax funds to reimburse yourself for your Eligible Dependent Care Expenses by entering into a Salary Redirection Agreement with your Employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is nontaxable; you save social security and income taxes on the amount of your salary conversion.

QUESTIONS & ANSWERS

Q-1. Who can participate in the Plan ?

Each Employee of the Employer who, not covered by a collective bargaining agreement, and is eligible to participate in the related Flexible Benefits Plan.

Q-2. How do I become a Participant ?

By electing DCR benefits during the Initial or Annual Enrollment Periods.

Q-3. What is my "Dependent Care Expense Reimbursement Account" ?

If you elect benefits under this portion of the Plan, a non-interest bearing Dependent Care Expense Reimbursement Account ("Account") will be set up in your name to keep a record of the reimbursements you are entitled to.

Q-4. What is the maximum DCR benefit I may elect ?

This amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code.

The maximum amount is currently \$ 5,000 per Plan Year if you ---
--- are married and file a joint return;
--- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DCR, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return;
--- are single, or a head of household for tax purposes.

If you are married, reside together, but file a separate federal income tax return, the maximum benefit you may elect is \$ 2,500.

Q-5. How is my Account funded ?

When you complete the Salary Redirection Agreement, you specify the amount of DCR benefits for which you wish to pay with your salary reduction. Thereafter, your Account will be credited with that portion of your gross income you have elected to forego through salary reduction. These portions will be credited as of each pay period.

For example, suppose you have elected to be reimbursed for \$ 2,600 per year for Eligible Employment Related Expenses, and you have chosen no other benefit under the Employer's Flexible Benefits Plan. Your Account would be credited (and funded) with a total of \$ 2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of \$ 100.00 credited to your Account each payday to pay reimbursements under this Plan. The amount that is available to your Account at any particular time will be whatever has been credited to such Account less any reimbursements already paid.

Q-6. What is an "Eligible Expense" for which I can claim a reimbursement ?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself; or your Spouse, if the Spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet *all* of the following conditions for them to be Eligible Dependent Care Expenses;

1. The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.
2. Each individual for whom you incur the expense is:
 - (A) a Dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or
 - (B) a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
5. If the expenses are incurred for services provided by a dependent care center (i.e. a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expenses are not paid or payable *to* a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:
 - (a) \$ 5,000.
 - (b) \$ 2,500 if you are married but you and your Spouse file separate tax returns.
 - (c) Your taxable compensation (after your salary reduction under the Flexible Benefits Plan).
 - (d) If you are married, your Spouse's actual or deemed Earned Income.

For purposes of (d) above, your Spouse will be deemed to have Earned Income of \$ 200 (\$ 400) if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time Student.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-7. How do I receive reimbursement under the Plan ?

If you have elected to participate in this portion of the Plan, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. If there are enough credits to the Dependent Care Expense Reimbursement Account, you will be reimbursed for your eligible expenses within a week.

If your claim was for an amount that was more than your current Account balance, the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Account. You may not be reimbursed for any expenses that arise before your Salary Redirection Agreement becomes effective, or for any expense incurred after the close of the Plan Year, except during the "Temporary Carry-Over Period" of 2 ½ months following the close of each Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

In order to be reimbursed for your current expenses within a week, you must submit your Claim Form directly to the Plan Administrator on or before 5:00 PM on Tuesdays of each week. In addition, you will have 2 ½ months after the end of each Plan Year in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year, and during the subsequent "Temporary Carry-Over Period". You will be notified in writing if any claim for benefits is denied.

Q-8. What if the Eligible Employment Related Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Expense Reimbursement ?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual coverage you have elected and paid for, on the other. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year within 2 ½ months following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs.

Q-9. Will I be taxed on the DCR benefits I receive ?

You will not normally be taxed on your DCR benefits, up to the limits in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-10. If I participate in the DCR, will I still be able to claim the household and dependent care credit on my federal income tax return ?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified dependent care expenses may be eligible for the dependent care credit.

Q-11. What is the household and dependent care credit ?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$ 2,400 of such expenses for one Dependent, or \$ 4,800 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of \$ 720 for one Dependent or \$ 1,420 for two or more Dependents,) to a minimum of 20% of such expenses (producing a maximum credit of \$ 480 for one Dependent or \$ 960 for two or more Dependents.) The maximum 30% rate must be reduced by 1% (but not below 20%) for each \$ 2,000 portion (or any fraction of \$ 2,000) of your adjusted gross incomes over \$ 10,000.

Illustration: Assume you have one Dependent for whom you have incurred Eligible Expenses of \$ 3,600 and that your adjusted gross income is \$ 20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$ 2,400 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 30% for each \$ 2,000 of your adjusted gross income over \$ 10,000. The calculation is: $30\% - \{(\$20,000 - 10,000) / \$2,000 \times 1\% \} = 25\%$. Thus, your tax credit would be $\$ 2,400 \times 25\% = \$ 600$. If you had incurred the same expenses for two or more Dependents, your credit would have been $\$ 3,600 \times 25\% = \$ 900$ because the entire expense would have been taken into account, not just the first \$ 2,400.

Q-12. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursement as tax-free ?

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by including the DCR benefits in income, and claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat DCR benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g. married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-13. Forfeiture of Unclaimed Reimbursement Account Benefits

Any Reimbursement Account benefit payments that are unclaimed (e.g. uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited.

PART IV. ELECTING LESS THAN THE MAXIMUM ANNUAL BENEFIT

Any portion of your Compensation that you do not choose to apply toward the purchase of the benefits above will be paid to you as regular, taxable Compensation.

PART V. ERISA RIGHTS

ERISA Rights Statement

As a Participant in the Flexible Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all plan documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of all plan documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue Medical Expense Reimburse Plan coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HIPAA Special Enrollment Rights

After declining health coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after your other coverage ends.

New dependents. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request for enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you add coverage under these instances, the maximum length of any preexisting condition exclusion under this plan is 12 months. However, a preexisting condition exclusion does not apply to the pregnancy of you or, if applicable, your covered spouse, or to any newborn or adopted child who is added to the coverage within 30 days of the birth or adoption.

PART VI. GENERAL INFORMATION

This Section contains certain general information that you may need to know about the Plan.

1. General Plan Information

MILLICAN & ASSOCIATES EMPLOYEE'S CAFETERIA PLAN is the name of the Plan.

Your employer has assigned Plan Number 501 to your Plan. The provisions of the Plan described herein originally became effective on April 1, 1993.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on April 1st and ends on March 31st.

2. Employer Information

Your Employer's corporate headquarters is located at:

MILLICAN & ASSOCIATES
5850 Coral Ridge Drive, Suite 205
Coral Springs, FL 33076

3. Plan Administrator Information and Service of Legal Process

MILLICAN & ASSOCIATES
5850 Coral Ridge Drive, Suite 205
Coral Springs, FL 33076
Attention: Traci Cravens, Human Resources Administrator

4. Contract Administrator

Your Employer has engaged the services of a Contract Administrator also known as a Third-Party Administrator who will be responsible for the administration of the Plan. The Third-Party Administrator will also answer any questions you may have about our Plan, and will process claims for reimbursement for the Medical and Dependent Care Reimbursement Plans. You may contact our Third-Party Administrator at the address and phone number listed below about the Plan.

KCI Financial Services, Inc.
11011 Sheridan Street, Suite 202
Cooper City, FL 33026
(954) 443-4443 -- office
(954) 443-4445 -- fax

APPENDIX C.
FLEXIBLE BENEFIT CREDIT DOLLARS

(Not Applicable)