CONNER STRONG

INFORMATION ABOUT SECTION 125 PREMIUM ONLY PLAN ("POP")

On March 22, 2010 New Jersey Gov. Chris Christie signed into law broad changes to pensions and benefits offered to public workers. This law requires that all government workers – state and local – contribute at least 1.5% of their salaries towards the cost of their health benefits. In order to allow plan participants to pay the 1.5% on a pre-tax basis, government entities will need to have set up a Premium Only Plan under Section 125 of the Internal Revenue Code (a "POP"). In general, ERISA does not apply to Section 125 cafeteria (POP) plans, but it does apply to many welfare benefit plans offered under cafeteria plans. However, governmental plans as defined by ERISA § 3(32) are exempt from Title I of ERISA. However, unlike the exemption under ERISA, there is no exemption for non-federal governmental cafeteria plans from the Code's requirements that apply to cafeteria plans—the Code applies to such plans. As a result, such plans must follow the cafeteria plan rules, both in form (a plan document is required) and in operation. We note too that while a plan document is required for a non-federal governmental cafeteria plan, no Form 5500 reporting or summary plan description (SPD) is required for a cafeteria plan.

To assist in your being prepared and able to offer workers the 1.5% contribution on a pre-tax basis, we have prepared a model plan document for use by public entity employers in New Jersey to assist in implementing an Internal Revenue Code Section 125 plan. The attached model document assumes that the plan year is a calendar year. Certain Articles and Sections must be customized in the attached document based upon the benefits and eligibility features of an employer. We recommend that this document and the establishment and administration of the cafeteria plan be reviewed by your legal counsel prior to its implementation as a Code Section 125 Plan. State law questions will be of particular importance and should be reviewed with an attorney versed in the applicable state law. Nothing contained in the attached model document is intended to constitute legal advice regarding whether any plan or program offered by an employer constitutes an Internal Revenue Code Section 125 plan.

Establishing a Section 125 POP plan will enable government workers to get tax savings on the contributions they make toward the purchase of health insurance. Thus, if a POP cafeteria plan is set up, employees can choose to reduce their salary to pay their health insurance contribution on a before tax basis. In other words, employees can choose a nontaxable benefit (health insurance contributions) instead of cash (unreduced salary). Employees can also choose between paying their health insurance contribution on a pre-tax basis under the POP plan or on an after-tax basis outside of the POP plan. An employee who chooses the after-tax route would receive his or her full salary in cash (no salary reduction election would be made under the POP plan) and make the payment for the health insurance contribution with after-tax dollars. The attached model Section 125 POP plan is also written to allow for a taxable waiver payment where workers have coverage elsewhere. Under this provision, the plan provides that an employee may be paid additional (taxable) cash compensation in exchange for forgoing the (nontaxable) health insurance benefit.

Conner Strong has prepared the model plan document for your convenience. If you elect to use the model document, your counsel should review it to make any adjustments or language modifications that may be necessary to meet any unique requirements that may be in place. Remember that if you do not set up a Section 125 POP you cannot offer workers the opportunity to pay the 1.5% contribution on a pre-tax basis. You are also under no obligation to set up a Section 125 POP. You only need to do so if you elect to calculate the 1.5% deduction on a pre-tax basis. Deducting the 1.5% on a pre-tax basis reduces the employees' taxable income and also the amount of employer taxes as well.

If you have questions regarding the attached or about a Section 125 POP, please contact your Conner Strong account representative at 1-877-861-3220.

(See attached Template Section Premium Only Plan)

Premium Only Section 125 Plan with Opt-Out

for

_____

(insert Plan Sponsor name)

This document has been prepared as a model plan document *to assist a public entity employer in New Jersey in implementing an Internal Revenue Code Section 125 premium only with opt-out provision plan. The document assumes that the plan year is a calendar year*. Certain Articles and Sections must be customized based upon the benefits and eligibility features of an employer. Before you adopt it (in accordance with your standard business governance procedures), you should verify its accuracy and appropriateness for your benefit programs, and your legal advisor(s) should review and approve it. Nothing contained in this model document is intended to constitute legal advice regarding whether any plan or program offered by an employer constitutes an Internal Revenue Code Section 125 plan.

April 2010 DRAFT

ARTICLE I
ESTABLISHMENT AND PURPOSE OF THE PLAN

The Plan Sponsor has established the Plan for the purpose of providing those employees of the Plan Sponsor who are eligible to participate in the Plan with a choice between receiving cash (in the form of unreduced compensation or taxable benefits treated as cash) or of receiving certain Benefits under such health benefit arrangements as may be in effect for the Plan Sponsor's employees from time to time (the "Health Care Program"). In addition, the Plan offers employees who are eligible to elect the Health Care Program the right to elect to receive a taxable payment in lieu of Health Care Benefits (the "Health Premium Waiver Benefit"). It is the Plan Sponsor's intention that (1) the Plan qualify as a "cafeteria plan" as that term is defined in Section 125(d)(1) of the Internal Revenue Code of 1986, as amended (the "Code") and (2) the Health Care Benefits offered under the Plan qualify for exclusion from the gross income of participating employees under Code Section 125, and such other sections of the Code as may be applicable. It is also the intention of the Plan Sponsor that the Plan be interpreted in a manner consistent with the requirements of Section 125 of the Code, Treasury Regulations promulgated by the IRS thereunder, and any other requirements of the Code and/or Treasury Regulations as may be applicable in connection with the qualification for exemption from gross income of the Health Care Benefits offered under the Plan.

ARTICLE II
DEFINITIONS

2.1 Benefit and Benefit Options means any health care benefit, including but not limited to, medical, dental, vision or similar benefits offered under the Plan.

2.2 Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations thereunder and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.3 Compensation means remuneration paid by the Plan Sponsor that is includable in gross income, before reduction for nontaxable contributions to this Plan (or other benefit plan), not including amounts available before an Employee is eligible for the Plan.

2.4 Effective Date means the date the Plan Sponsor has established the Plan for the purpose of providing those employees of the Plan Sponsor who are eligible to participate in the Plan with a choice between receiving cash (in the form of unreduced compensation or taxable benefits treated as cash) or of receiving certain Benefits under such health benefit arrangements as may be in effect for the Plan Sponsor's employees from time to time (the "Health Care Program").

2.5 Election Form means any appropriate election form to include electronic forms provided by the Plan Sponsor or Plan Administrator or any person providing benefits under the Plan for the purposes of electing to participate in Benefit Options and authorizing Salary Reduction Contributions to pay for such Benefit Options under the Plan.

2.6 Eligible Employee means an Employee who is not an Excluded Employee.

2.7 Employee means any person performing services under the direction and control of the Plan Sponsor who is either (i) currently in pay status of the Plan Sponsor, including, but not limited to, paid sick leave, paid vacation, and paid administrative leave, or (ii) on unpaid authorized leave from an Plan Sponsor. The term Employee shall not include any individuals hired to perform services for an Plan Sponsor as leased employees, agency contract personnel or independent contractors, and their respective employees or agents, notwithstanding that such individuals may be subsequently re-classified by a court, government agency, tribunal or arbitrator as common law employees of a Plan Sponsor.

2.8 Excluded Employee means any (i) Employee excluded from participation hereunder by the Plan Sponsor; (ii) Employee who is a member of a collective bargaining unit to which this Plan has not been extended; (iii) leased employee within the meaning of Code Section 414(n); and (iv) independent contractors or agency contract personnel; provided, however that if a leased employee, independent contractor, or contract worker is reclassified as an “employee” by any Federal or state agency such shall continue to be an Excluded Employee for the remainder of the Plan Year in which such reclassification determination occurs.

2.9 FMLA means the Family and Medical Leave Act of 1993.

2.10 FMLA Leave means a leave of absence provided to an Employee subject to and pursuant to the terms of the FMLA.

2.11 Health Premium Waiver Benefit means a payment made by the Plan Sponsor on an after-tax basis to an Eligible Employee in lieu of the Eligible Employee's participation in Health Care Benefits during the Plan Year provided the Eligible Employee (i) elects to waiver his/her participation in Health Care Benefits and (ii) completes the appropriate benefits waiver forms.

2.12 Health Care Benefits means any health benefit arrangement, including but not limited to, medical, dental, vision or similar benefits provided through contract or policies with a Provider entered into by the Plan Sponsor from time to time for this purpose or provided by the Plan Sponsor from time to time for this purpose, the Premiums for which are paid by the Plan Sponsor and/or the Participant.

2.13 Health Continuation Coverage means the continuation of Health Care Benefits in accordance with the Public Health Service Act.

2.14 HIPAA means the Health Insurance Portability and Accountability Act of 1996, the regulations promulgated thereunder, and any amendments to either.

2.15 Key Employee means an individual who is a key employee within the meaning of Code Section 416.

2.16 Leave of Absence means any leave of absence approved by the Plan Sponsor, including, but not limited to, FMLA Leave and/or a period of duty in the Uniformed Services.

2.17 Open Enrollment Period means the general election period held prior to the beginning of each Plan Year. The dates of the general election period will be determined annually and announced in advance by the Plan Administrator.

2.18 Participant means an Eligible Employee who has elected to participate in the Benefits offered under the Plan in accordance with Article III.

2.19 Period of Coverage means the Plan Year, or for an Employee who first becomes eligible to participate in the Plan or Benefit Option during a Plan Year, the remainder of such Plan Year, or to the extent applicable, the Period of Coverage is any other shorter period as may result from a permitted or required change to a Participant's Benefit Option elections made during a Plan Year.

2.20 Plan means the Premium Only Section 125 Plan with Opt-Out as set forth herein, together with any and all amendments and supplements hereto.

2.21 Plan Administrator shall mean the Plan Sponsor or such other person or committee as may be appointed from time to time by the Plan Sponsor to supervise the administration of the Plan.

2.22 Plan Sponsor shall mean the government entity, municipality, township, etc. identified on the title page of this document.

2.23 Plan Year means the twelve (12) month period beginning on January 1 and ending on December 31 of each year.

2.24 Premium or Premiums means the portion of premium cost that a Participant is required to contribute for the coverage designated under the Benefits in which the Participant has elected to enroll pursuant to Article III.

2.25 Provider means a licensed insurance company that has issued a group policy or contract under any of the Benefits offered under the Plan.

2.26 Qualified Benefit means any Benefit which, with the application of Code Section 125(a), is not includable in the gross income of an Employee by reason of an express provision of Chapter 1 of the Code.

2.27 Salary Reduction Agreement means a written agreement on an Election Form prescribed by the Plan Administrator entered into by the Plan Sponsor and the Eligible Employee under which the Eligible Employee's Compensation is reduced to pay for Qualified Benefits through Salary Reduction Contributions.

2.28 Salary Reduction Contribution means the amount by which a Participant's Compensation is reduced to pay for Benefits through this Plan.

2.29 Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

2.30 USERRA means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended from time to time.

ARTICLE III
ELIGIBILITY

3.1 Initial Participation in the Plan. Any Eligible Employee of the Plan Sponsor shall be eligible to participate in the Plan as of his or her eligibility to participate in the Plan and upon completion of the appropriate Election Form filed with the Plan Administrator.

3.2 Participation During Leave of Absence. Any Participant who is absent from work due to a Leave of Absence shall have the right to continue to participate in the Benefits offered through the Plan during the period the Participant is on such Leave of Absence, unless the terms on which the Leave of Absence was approved limit the Participant's ability to continue such participation; provided, however, that no such limitation shall be implemented that would be in conflict with any applicable law or regulations, including, but not limited to, the rules and regulations that govern FMLA leave. If the Participant does not return to active employment before expiration of any such limitation on his or her ability to continue to participate in the Benefits, his or her participation in the Plan shall cease. The Participant's right to continue participation while on Leave of Absence (other than such permitted continued coverage) is conditioned upon the Participant (i) continuing to have an employment relationship with the Plan Sponsor, and (ii) making any required payments of premiums or other contributions.

3.3 Termination of Participation. A Participant shall cease participation in the Plan upon the earliest of the following events:

(a) the day on which he ceases to be an Eligible Employee or such earlier date on or after the date the Participant ceases to be an Eligible Employee as provided under the terms of any insurance policy or other documentation specific to one or more of the Benefits covering the Participant;

(b) the date on which the Plan is terminated under Section 4.3;

(c) with respect to benefits toward the cost of which the Participant is required to contribute, the date as of which he fails to make a required contribution;

(d) the date on which the Participant elects to cease coverage;

(e) the date of death of the Employee.

ARTICLE IV
BENEFIT ELECTIONS AND BENEFITS

4.1 Benefits.

(a) The Benefits provided under the Plan, to the extent not specifically described herein, are described in the policies, contracts, or other created under the Plan ("separate documents") which are incorporated herein by reference and made available to Plan Participants. Any restrictions, limitations, and additional requirements relating to a Participant's entitlement to Benefits that are not set forth in the Plan are described in the separate documents for the specific Benefit. The Provider shall provide the benefits due under the respective Benefit directly to the Participant, spouse, dependents, or named beneficiaries, if appropriate, according to the terms of such Benefit. The only benefits available under an insured Benefit are those expressly provided for under the terms of the applicable policy or contract.

(a) A Participant may elect between receiving (i) Compensation or having Salary Reduction Contributions made to the Plan by the Plan Sponsor to provide for the Participant's share of Premiums for Health Care Benefits; or (ii) the Health Premium Waiver Benefit. A Participant may also elect to pay the Participant's share of Premiums for Health Care Benefits on an after-tax basis.

4.2 Timing and Irrevocability of Elections. In general, an election of Salary Reduction Contributions under the Plan must be made before the first day of the Period of Coverage, as applicable. Such election must be made in accordance with the rules and procedures established by the Plan Administrator. The election shall be irrevocable for that entire Plan Year, except as provided in Sections 4.7, 4.8 or 4.9.

4.3 Election Procedure for Current Employees. An Eligible Employee may enroll in the Plan by making an election under this Plan during the Open Enrollment Period. During the Open Enrollment Period, each Eligible Employee may make an election for the upcoming Plan Year or the remainder of a Plan Year in accordance with such procedures as the Plan Administrator prescribes. The maximum amount of elective contributions under the Plan for any Participant shall be the total cost to the Participant for the Period of Coverage of the most expensive Benefit that any Participant could elect.

4.4 Election Procedure for New Employees. The Plan Administrator shall provide the Election Form to a newly hired Eligible Employee as soon as administratively feasible after the Employee is hired. Such Eligible Employee must return a completed Election Form to the Plan Administrator on or before the date the Plan Administrator specifies in order to elect Salary Reduction Contributions for benefits for the upcoming Plan Year or remainder of the current Plan Year. Salary Reduction Contributions shall not begin earlier than the date that the Plan Administrator receives the completed Election Form.

4.5 Election Procedures For Rehires. In the case of a Participant who ceases to be employed by the Plan Sponsor and is subsequently rehired within one year, such Participant shall be eligible to participate again in the Plan upon his date of re-hire.

4.6 Failure to Return Election Form. A Participant or Eligible Employee who fails to return an Election Form timely shall be deemed to have elected not to participate in the Plan. Such deemed election will continue in effect for future Plan Years, unless and until the Participant submits an Election Form during a general election period, or at a time allowed under the rules in Section 4.7.

4.7 Change in Elections.

(a) Family Status Changes. An Eligible Employee who has not enrolled in the Plan may enroll and a Participant may modify or revoke an election for the remainder of a Plan Year, and make a new election, on account of and consistent with a change in family status recognized under the Plan, provided that the Eligible Employee or Participant files such change with the Plan Administrator on an Election Form and provides the Plan Administrator with any requested forms or documentation within thirty-one (31) days of the date of the event constituting the family status change. A change in family status for this purpose may include the following: (i) marriage; (ii) divorce; (iii) legal separation; (iv) annulment; (v) death of a Spouse or Dependent; (vi) birth, adoption, or placement for adoption of a child; (vii) termination or commencement of employment of a Spouse or Dependent; (viii) the termination of Participant's employment; (ix) other changes in the employment status of the Participant, Spouse, or Dependent resulting in eligibility or ineligibility for coverage under one or more Benefit Options; (x) change in residence of the Participant, Spouse or Dependent, which affects such individual's eligibility under a Benefit Option; (xi) changes which cause a Dependent to become eligible or ineligible for coverage under the Benefit Options; (xii) the taking of a leave of absence by the Participant, Spouse or Dependent; (xiii) the loss of or a significant change in benefit coverage of the Participant, Spouse, or Dependent attributable to the Spouse's or Dependent's employment; or (xiv) other events that are permitted by the Code and approved by the Plan Administrator. A benefit election change is consistent with a family status change only if necessary or appropriate as a result of the family status change. The Plan Administrator, in its sole discretion, shall determine which family status changes are permissible under the Plan and whether a benefit election change is consistent with such family status change.

(b) State Children's Health Insurance Program ("SCHIP") Enrollment Rights. If an Eligible Employee or his/her Dependent has either (1) a termination of Medicaid or SCHIP coverage resulting from a loss of eligibility or (2) becomes eligible for premium assistance in the Plan under either Medicaid or the SCHIP program, the Eligible Employee may enroll in the Plan provided the eligible Employee requests coverage within 60 days of the termination or the date the Eligible Employee and/or his/her Dependent is determined to be eligible for assistance.

(c) Medicare and Medicaid. If a Participant or his or her spouse or dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her spouse or dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(d) HIPAA Special Enrollment Rights. If a Participant or his or her spouse or dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(i) Participant or his or her spouse or dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under the continuation coverage rules of the Public Health Service Act or the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the continuation coverage was exhausted; or (2) the coverage was non-continuation coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

(ii) a new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days). For purposes of this Section, the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(a) Significant Cost or Coverage Changes.

(i) Automatic Changes. If the cost of a Qualified Benefit increases (or decreases) during a Period of Coverage, and Participants are required to make a corresponding change in their Premiums, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the Participants' Salary Reduction Contributions under the Plan unless Section 4.7(c)(ii) applies.

(ii) Significant Cost Increases. If the cost of a Qualified Benefit significantly increases during a Period of Coverage, the Plan Administrator may permit Participants either to make a corresponding prospective increase in their Salary Reduction Contributions, or to revoke their elections and, in lieu thereof, to elect on a prospective basis coverage under another coverage option providing similar coverage under such Benefit.

4.8 Termination of Employment or Eligible Employee Status. If a Participant terminates employment or otherwise ceases to be an Eligible Employee elections hereunder shall be deemed revoked.

4.9 Change of Elections for Legal Compliance. The Plan Administrator shall have the authority to reject, amend or revoke any election of Salary Reduction Contributions to the extent necessary to assure that the Plan and all benefits provided under the Plan comply with applicable legal requirements. This includes actions to treat what would otherwise have been Salary Reduction Contributions as taxable Compensation in order to comply with the nondiscrimination rules imposed by Code Section 125, and any other Code provisions that may apply to the Plan from time to time. Actions under this paragraph shall be undertaken on a non-discriminatory and consistent basis, and shall not require the consent of affected Participants.

4.10 Procedures. Consistent with the requirements set forth in this Article, the Plan Administrator may prescribe further uniform and nondiscriminatory rules for elections.

4.11 Benefit Providers. Any benefits available under the Plan shall be provided by those insurers or other health care providers with whom the Plan Sponsor has arranged for the provision of such benefits. The terms of the Heath Care Benefits available under the Plan are, however, established by the insurers or other health care providers with whom the Plan Sponsor has arranged for such benefits, and the types and amounts of benefits available from any such insurers or other health care providers will be subject to the terms of the applicable insurance policies, contracts, and any other specific terms, conditions, and limits for coverage as are set forth from time to time. The requirements, terms, conditions and limitations applicable with respect to such coverage and the benefit descriptions as are set forth in such plans and contracts as may be in effect from time to time, shall be provided to Participants and are incorporated into the Plan by reference.

4.12 Discretion of the Plan Administrator. The Plan Administrator shall also have the authority to administer the Plan, and all provisions of the Plan are to be interpreted and administered by the Plan Administrator in such a manner as to satisfy the nondiscrimination rules established by Section 125(b) of the Code and applicable Treasury Regulations thereunder during each Plan Year. In addition, in connection with the continued qualification for exclusion from employees' income of all benefits intended to constitute health care benefits under the Plan, the Plan Administrator shall have the authority to reduce benefits or change elections with respect to "key employees" (as defined in Section 414(q) of the Code) or "highly compensated participants" (as defined in Section 125(e) of the Code) and to take any other actions to the extent the Plan Administrator determines that such change or action is necessary or appropriate to ensure that all relevant Code requirements, including the limitations imposed on benefits for "key employees" applicable to the Plan under Code Section 125 and IRS regulations promulgated thereunder, are met.

ARTICLE V
QUALIFICATION, AMENDMENT AND TERMINATION

5.1 Qualification. The Plan shall be and remain qualified under Code Sections 105, 106, and 125, respectively. The Plan Sponsor may authorize any modification or amendments to the Plan, which may be retroactive, deemed necessary, or appropriate in its opinion to qualify or maintain the Plan as a plan meeting the requirements of Code Sections 105, 106, and 125 of the Code, or any other applicable provisions of the Code, and the regulations issued thereunder.

In order for the Plan to remain a qualified plan pursuant to Code Section 125, nontaxable benefits provided to Employees who are classified as Key Employees shall not exceed twenty-five percent (25%) of the total nontaxable benefits provided to all Employees. In the event that nontaxable benefits to such Key Employees shall exceed twenty-five percent (25%) of the total nontaxable benefits provided to all Employees, then such Key Employees receiving benefits shall be treated as though they received all available taxable benefits under the Plan.

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any non-discrimination requirement or any limitation on benefits provided to Key Employees or Highly Compensated Employees as applicable under the Code to the Plan, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under the rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or Key Employees with or without the consent of such Participants and Employees.

5.2 Amendment of Plan. Except as otherwise provided herein, the Plan may be amended at any time, and from time to time. The Plan Sponsor has sole discretion to amend or modify the Plan, provided that any such amendment or modification of the Plan shall not affect a Participant's right to benefits covered under the Plan prior to the effective date of the amendment.

5.3 Termination of Plan. The Plan Sponsor expressly reserves the right to terminate the Plan with respect to all Participants and Eligible Employees at any time and for any reason without liability. Termination of the Plan shall not affect the right of Participants, or their Spouses, Dependents and beneficiaries to reimbursement for covered benefits incurred prior to the effective date of termination of the Plan.

5.4 No Vesting or Contractual Rights to Benefits. No person shall have any contractual right to benefits under the Plan which interferes with the amendment of the Plan pursuant to Section 5.2 or termination of the Plan pursuant to Section 5.3. The Plan Sponsor makes no promise to continue the Plan or any Benefits under the Plan in the future and rights to future benefits do not vest.

ARTICLE VI
ADMINISTRATION OF PLAN

6.1 Duties and Authority of Plan Administrator. The Plan shall be administered by the Plan Sponsor, or by such person as may be appointed by the Plan Sponsor to act as the administrator for the Plan (such person or the Plan Sponsor, in its role as administrator of the Plan, is referred to herein as the "Plan Administrator"). The Plan Administrator shall have the responsibility to see that the Plan is operated in accordance with the provisions of the Plan document for the exclusive benefit of those persons eligible to participate in the Plan. The Plan Administrator shall have the authority to interpret any provisions of the Plan and shall have the power to administer the Plan and to take any and all actions as may be appropriate with respect to the Plan, including, but not limited to, the following:

(a) Decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(b) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(c) Interpret the Plan in good faith, in which event the Plan Administrator's interpretations shall be treated as final and conclusive; and

(d) Appoint or engage such persons whose services may be necessary or appropriate to the proper administration of the Plan and to allocate or delegate its responsibilities as Plan Administrator to other persons.

In administering the Plan, the Plan Administrator shall ensure that no discretionary actions taken by it shall have the effect of causing the Plan to be operated in a discriminatory manner, and that any administrative rules or procedures as may be established by the Plan Administrator shall be fashioned and applied in a uniform manner causing similarly situated individuals to be treated in substantially the same manner.

6.2 Plan Records and Documents. The Plan Administrator shall make copies of the Plan description, the latest annual report and any other instruments under which the Plan is established or operated, available for examination by any Participant or beneficiary upon such person's request at reasonable times during normal business hours at the principal place of business of the Plan Administrator or at such other locations as may be appropriate or required under applicable regulations promulgated by the Department of Labor.

6.3 Reliance. The Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on any tables, valuations, certificates, opinions, or reports furnished by, or in accordance with the instructions of, Plan benefit insurers or providers, or by accountants, counsel, or other experts employed or engaged by the Plan Administrator or the Plan Sponsor, unless the Plan Administrator knows or has reason to know that such documents or information is not correct.

6.4 Indemnification. The Plan Sponsor agrees to indemnify and defend, to the fullest extent permitted by law, any employee appointed to serve as the Plan Administrator or designated as a fiduciary with respect to the Plan against all liabilities, damages, costs, and expenses (including attorney fees and amounts paid in settlement of any claims approved by the Plan Sponsor) resulting from any act, or omission to act, in connection with the Plan provided such act or omission was made in good faith.

6.5 Expenses. The Plan Administrator's expenses, including the fees and costs of any service providers engaged to provide services to the Plan, shall be paid by the Plan Sponsor.

6.6 Reports. The Plan Administrator shall file or arrange to have filed all annual reports, forms, notices, and other reports and documents required by law, and shall provide or arrange to provide all notices and statements required by law to be made to employees and beneficiaries.

ARTICLE VII
MISCELLANEOUS

7.1 Source of Payments. All benefits paid under the Plan shall be paid from the general assets of the Plan Sponsor. No Employee shall have any rights to benefits under the Plan other than the unsecured right to receive payments due under the Plan. The Plan Sponsor shall not be obligated to set aside, earmark, or escrow any funds or assets to satisfy any obligation imposed upon it by the Plan. If the Plan Administrator is a person or committee rather than the Plan Sponsor, such Plan Administrator shall not be personally liable for the payment of any benefits under the Plan.

7.2 Nonalienation. Except to the extent required by law, the interest of Participants and their beneficiaries under the Plan are not subject to the claims of their creditors and may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, except as may be required to comply with the terms of a medical child support order. The Plan Sponsor shall in no event be liable for, or subject to, the debts, contracts, liabilities, or torts of any person entitled to or claiming benefits under the Plan.

7.3 Information to Be Furnished. Participants shall provide the Plan Sponsor and Plan Administrator with such information and evidence, and shall sign such documents as may be reasonably requested from time to time for the purpose of administration of the Plan.

7.4 Governing Law. The provisions of the Plan shall be construed, administered, and enforced in accordance with the laws of the State of New Jersey other than its laws respecting choice of law, to the extent not preempted by federal law.

7.5 Construction. The provisions of the Plan shall be interpreted and construed in accordance with the requirements of the Code.

7.6 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether any payment or benefit is excludable under the Participant's gross income and to notify the Plan Sponsor if the Participant has reason to believe that any such payment is not so excludable.

7.7 Severability. If any provision of the Plan is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such illegal or invalid provision had never been set forth in the Plan.

7.8 No Expansion of Employment Rights. The adoption of the Plan and the payment of any benefit shall not be construed as granting to any Participant or other person any continuing right to be employed, or any other right or benefit in connection with employment or any legal or equitable right against the Plan Administrator or Plan Sponsor. Nothing in the Plan shall be construed to limit the Plan Sponsor's right to discharge any Employee with or without cause.

7.9 Gender and Number. As used in the Plan, and unless otherwise plainly required by the context, any genders may be construed to include all genders, and the singular or plural may be construed top include the plural or singular, respectively.

IN WITNESS WHEREOF, and as evidence of the adoption of this Plan by the Plan Sponsor, this Plan is hereby executed this _____ day of _____, 20____.

BY:_____

DATE:_____