



PRICE AGREEMENT

This AGREEMENT, made this 1st day of February in the year Two Thousand Eight by and between Tri-Star Benefit Systems, Inc., hereinafter call the "Contractor" and **THE METROPOLITAN ST. LOUIS SEWER DISTRICT**, hereinafter called the "District".

WITNESSETH:

WHEREAS, through Authorization of the Director, of Engineering adopted December 13, 2007 by Ordinance No. 12556 execution of this Contract on the District's behalf,

NOW, THEREFORE, the Contractor and the District, for the consideration hereinafter specified, agree as follows:

Article 1. SCOPE OF WORK

The Contractor shall provide Flexible Benefit Administration for the District's in accordance with the solicitation RFP 08-029, addendums, and Board Approved Ordinance 12556.

Article 2. CONTRACT DOCUMENTS

The complete Contract shall be comprised of (1) this instrument; (2) the District's request for Proposal (RFP); and (3) the Proposal submitted by the Contractor in response to said RFP. In the event of conflict in the language between the aforesaid RFP and the Proposal, the provisions set forth in the RFP shall govern. In the event of conflict in the language between this instrument and either the RFP or the Proposal, the provisions of this instrument shall govern.

Article 3. TERM

The term of this contract shall be in accordance with Ordinance No 12556 and any approved resolutions affecting this contract, and shall be renewable at the District's option. The District reserves the right to terminate this agreement as provided for in the RFP Terms and Conditions for Termination for Convenience and/or Termination for Default.

Article 4. RATES

The rates shall be those reflected in Request for Proposal 08-029 and referenced documents accepted by the District. This price agreement has firm prices for the first year of the contract and there are escalation/de-escalation provisions that affect the option years.

Article 5. PAYMENT

The Director shall review each statement. Upon approval by the Director of Human Resources of all or part of the fees and expenses submitted by the Contractor, the District shall pay within thirty (30) days to the Contractor the amount so approved.

Article 6. INDEPENDENT CONTRACTOR

The Contractor shall be an independent Contractor for all purposes, and shall be entitled to no compensation other than the compensation provided under this contract.

Article 7. HOLD HARMLESS

The Contractor shall keep the District free and harmless from payment of any damages, costs, expenses, royalties, patent fees, lawyers' fees, or sums of money whatsoever by reason of any activity or performance of duties in connection with this project or agreement.

Article 8. INDEMNIFICATION

The Contractor shall defend, indemnify and save harmless the District, its Trustees and employees, from and against any and all loss, damages, liability, costs and expenses (including but not limited to attorneys' fees) arising out of any claim, including workers' compensation claims, suit or action against the District for or on account of any discrimination, personal injuries or bodily injury, including death, sustained or claimed to be sustained by any employee or agent of Contractor due, in whole or part, to the work, or by consequence of any hazard related to the work, or due, in whole or part, to any negligent act or omission on the part of the Contractor or any subcontractor, their agents or employees, related to the work and including any claim under workers' compensation for higher wage rates for work done for the District than the Contractor is paying to its own employees whom it provides to the District.

Article 9. AUTHORITY

The representatives signing on behalf of the parties certify that they are duly authorized by the party for which they sign to make this contract.

Article 10. DISPUTE RESOLUTION

The ordinances of The Metropolitan St. Louis Sewer District and the laws of the State of Missouri shall govern the Proposal and Contract in all respects, and any litigation with respect thereto shall be brought in the courts in the State of Missouri. The District and the Contractor agree to waive rights to a jury trial.

IN WITNESS WHEREOF, the Parties hereto have caused this Instrument to be executed in three (3) original counterparts as of the day and year first above written.

(SEAL)

Tri-Star Benefit Systems, Inc.
Contractor

Attest:

By [Signature]
CEO

By [Signature]
SECRETARY

Title

Title

2/18/2008

Date Signed By Contractor

MSD
(SEAL)

Attest:

[Signature]
Secretary-Treasurer

By [Signature]
Executive Director/CEO

Approved as to Form, Office of General Counsel:

2/26/08
Date

By [Signature]
General Counsel

I certify that this expenditure is within the appropriation to which it is being charged and that there is an unencumbered balance in the appropriation sufficient to pay this obligation or so much if it as may be payable during the current fiscal year.

2/27/08
Date

By [Signature]
Director of Finance

TRI-STAR BENEFIT SYSTEMS, INC.
 FLEXIBLE BENEFIT ADMINISTRATION PER ORD 12556
 0802-13-118
 MAXIMO VENDOR #10600, AMS VENDOR #11162C
 CONTACT: STEPHEN HARGRAVE
 CONTACT PHONE#: 314-985-0280

MSD STOCK #	COMMODITY CODE	DESCRIPTION	UOM	PRICE	BID IND
86227	95348991003	SERVICE; CLAIMS ADMIN, PRESCRIPTION EYEWEAR, PER EMP/MO	EA	\$0.38	BID
86228	95348991004	SERVICE; CLAIMS ADMIN, FLEXIBLE SPENDING ACCT, PER EMP/MO + \$.50/MO FOR DEBIT CARD SERVICES)	EA	\$4.70	BID

BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is made and executed this 17th day of February, 2010, by and between Metropolitan Sewer District, hereinafter referred to as "Plan Sponsor/Covered Entity", and Tri-Star Benefit Systems, Inc.

Tri-Star is engaged in the business of administering flexible benefit plans as described in IRC Section 125, administering Health Reimbursement Arrangements as described in Revenue Ruling 2002-41, and administering Group Health Plan Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended, hereinafter referred to as COBRA.

The Plan Sponsor hereby engages the services of Tri-Star to provide administrative services for the above plan(s), hereinafter referred to as "Plan".

Section I HIPAA Privacy & Security Definitions

(a) DEFINITIONS

- (1) Breach. "Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.
- (2) Business Associate. "Business Associate" shall mean Tri-Star Benefit Systems, Inc.
- (3) Covered Electronic Transactions. "Covered Electronic Transactions" shall have the meaning given the term "transaction" in 45 CFR § 160.103.
- (4) Plan Sponsor/Covered Entity. "Plan Sponsor/Covered Entity" shall mean Metropolitan Sewer District.
- (5) HHS. "HHS" shall mean the Department of Health and Human Services.
- (6) Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- (7) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and 164, Subparts A and E.
- (8) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Plan Sponsor/Covered Entity.
- (9) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 160.103.
- (10) Privacy Officer. "Privacy Officer" shall have the same meaning as set out in 45 CFR § 164.501, as such provision is currently drafted and as it is subsequently updated, amended or revised.
- (11) Standards for Electronic Transactions Rule. "Standards for Electronic Transactions Rule" means the final regulations issued by HHS concerning standard transactions and code sets under the Administration Simplification provisions of HIPAA, 45 CFR Part 160 and 162.

- *Electronic Protected Health Information.* "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103.
- *Security Incident.* "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 160.103.
- *Security Rule.* "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR Part 160 and Part 164, subpart C.

(12) Transaction. "Transaction shall have the meaning given the term "transaction" in 45 CFR § 160.103.

(13) Unsecured Protected Health Information. "Unsecured protected health information" shall have the meaning given the term "unsecured protected health information" in 45 CFR § 164.402.

Section II Safeguarding Privacy and Security of Protected Health Information

(a) PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Business Associate is permitted to use and disclose Protected Health Information that it creates or receives on Covered Entity/Plan Sponsor's behalf or receives from Covered Entity/Plan Sponsor (or another business associate of Covered Entity/Plan Sponsor) and to request Protected Health Information on Covered Entity/Plan Sponsor's behalf (collectively, "Covered Entity/Plan Sponsor's Protected Health Information") only:

(1) Services. Pursuant to the Plan Administration Agreement, Business Associate provides services ("Services") for the Plan Sponsor/Covered Entity that involve the use and disclosure of Protected Health Information. Except as otherwise specified herein, the Business Associate may make any and all uses of Protected Health Information necessary to perform its obligations under the Plan Administration Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, Business Associate may disclose Protected Health Information for the purposes authorized by this Agreement only, (i) to its employees, subcontractors and agents, (ii) as directed by the Plan Sponsor/Covered Entity, or (iii) as otherwise permitted by the terms of this Agreement including, but not limited to, Sections 2-4 below.

(2) Business Activities of the Business Associate. Unless otherwise limited herein, the Business Associate may:

- use the Protected Health Information in its possession for its proper management and administration and to fulfill any present or future legal responsibilities of the Business Associate provided that such uses are permitted under state and federal confidentiality laws.
- disclose the Protected Health Information in its possession to third parties for the purpose of its proper management and administration or to fulfill any present or future legal responsibilities of the Business Associate, provided that the Business Associate represents to the Plan Sponsor/Covered Entity, in writing, that (i) the disclosures are required by law, as provided for in 45 CFR § 164.103 or (ii) the Business Associate has received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 CFR § 164.103.

(3) Business Associate's Operations. For Business Associate's proper management and administration or to carry out Business Associates legal responsibilities, provided that, with the respect to disclosure of Covered Entity's Protected Health Information, the

Business Associate is permitted to use and disclose Protected Health Information as either:

- the disclosure is Required by Law; or
- Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Plan Sponsor/Covered Entity's Protected Health Information that the person or entity will:
 - i. Hold Plan Sponsor/Covered Entity's Protected Health Information in confidence and use or further disclose Plan Sponsor/Covered Entity's Protected Health Information only for which Business Associate disclosed Plan Sponsor/Covered Entity's Protected Health Information to the person or entity or as Required by Law; and
 - ii. Promptly notify Business Associate (who will in turn notify Plan Sponsor/Covered Entity in accordance with the breach notification provisions) of any instance of which the person or entity becomes aware in which the confidentiality of Plan Sponsor/Covered Entity's Protected Health Information was breached.

- (4) Minimum Necessary. Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of Plan Sponsor/Covered Entity's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate nor Plan Sponsor/Covered Entity is required to limit its use, disclosure, or request to the minimum necessary. Business Associate and Plan Sponsor/Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") passed as part of the American Recovery and Reinvestment Act of 2009, and government guidance on the definition.

(b) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE

Business Associate will neither use nor disclose Plan Sponsor/Covered Entity's Protected Health Information, except as permitted or required by this Agreement or in writing by Covered Entity/Plan Sponsor or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Plan Sponsor/Covered Entity's Protected Health Information in a manner that will violate the Privacy Rule if done by Plan Sponsor/Covered Entity.

(c) INFORMATION SAFEGUARDS

- (1) Privacy of Plan Sponsor/Covered Entity's Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Plan Sponsor/Covered Entity's Protected Health Information. The safeguards must reasonably protect Plan Sponsor/Covered Entity's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.
- (2) Security of Plan Sponsor/Covered Entity's Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on Plan Sponsor/Covered Entity's behalf as required by the Security Rule.

- (d) **SUBCONTRACTORS AND AGENTS.** Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Plan Sponsor/Covered Entity to disclose Plan Sponsor/Covered Entity's Protected Health and/or Electronic Protected Health Information, to provide reasonable assurance that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to Plan Sponsor/Covered Entity's Protected Health Information and/or Electronic Protected Health Information that are applicable to Business Associate under this agreement.
- (e) **PROHIBITION ON SALE OF RECORDS.** As of the effective date specified by HHS in final regulations to be issued on this topic, Business Associate shall not directly or indirectly receive remunerations in exchange for any Protected Health Information of an individual unless the Plan Sponsor/Covered Entity or Business Associate obtained from the individual, in accordance with 45 CFR § 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that individual, except as otherwise allowed under the HITECH Act.
- (f) **PENALTIES FOR NONCOMPLIANCE.** Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the privacy rule and security rule, as amended by the HITECH Act.

Section III Compliance with Electronic Transactions Rule

If Business Associate conducts in whole or part electronic Transactions on behalf of Plan Sponsor/Covered Entity for which HHS has established standards, Business Associate will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule. Business Associate shall also comply with the National Provider Identifier requirements, if and to the extent applicable.

Section IV Individual Rights

- (a) **ACCESS.** Business Associate will, within 15 calendar days following Plan Sponsor/Covered Entity's request, make available to Plan Sponsor/Covered Entity or, at Plan Sponsor/Covered Entity's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies Plan Sponsor/Covered Entity's Protected Health Information about the individual that is in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 CFR § 164.524. Effective as of the date specified by HHS, if the Protected Health Information is held in an Electronic Health Record, then the individual shall have a right to obtain from Business Associate a copy of such information in an electronic format. Business Associate shall provide such a copy to Covered Entity or, alternatively, to the individual directly, if such alternative choice is clearly, conspicuously, and specifically made by the individual or Covered Entity.
- (b) **AMENDMENT.** Business Associate will, upon receipt of written notice from Plan Sponsor/Covered Entity, promptly amend or permit Plan Sponsor/Covered Entity access to amend any portion of Plan Sponsor/Covered Entity's Protected Health Information, so that Covered Entity may meet its amendment obligations under 45 CFR § 164.526.
- (c) **DISCLOSURE ACCOUNTING.** To allow Plan Sponsor/Covered Entity to meet its disclosure accounting obligations under 45 CFR § 164.528:
 - (1) **Disclosure Subject to Accounting.** Business Associate will record the information specified below ("Disclosure Information") for each disclosure of Plan Sponsor/Covered Entity's Protected Health Information, not excepted from disclosure accounting as

specified below, that Business Associate makes to Plan Sponsor/Covered Entity or to a third party.

- (2) Disclosures Not Subject to Accounting. Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of Plan Sponsor/Covered Entity's Protected Health Information if Plan Sponsor/Covered Entity need not account for such disclosures.
 - (3) Disclosure Information. With respect to any disclosure by Business Associate of Plan Sponsor/Covered Entity's Protected Health Information that is not excepted from disclosure accounting, Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:
 - Disclosure Information Generally. Except for repetitive disclosures of Plan Sponsor/Covered Entity's Protected Health Information as specified below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which Business Associate made the disclosure, (iii) a brief description of Plan Sponsor/Covered Entity's Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure.
 - Disclosure Information for Repetitive Disclosures. For repetitive disclosures of Plan Sponsor/Covered Entity's Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including Plan Sponsor/Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified above for each accountable disclosure, or (i) the Disclosure Information specified above for the first repetitive accountable disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.
 - (4) Availability of Disclosure Information. Business Associate will maintain the Disclosure Information for at least 6 years following the date of the accountable disclosure to which the Disclosure Information relates (3 years for disclosures related to an Electronic Health Record, starting with the date specified by HHS). Business Associate will make the Disclosure Information available to the Plan Sponsor/Covered Entity within 45 calendar days following the Plan Sponsor/Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting. Effective as of the date specified by HHS, with respect to disclosures related to an Electronic Health Record, Business Associate shall provide the accounting directly to an individual making such a disclosure request, if a direct response is requested by the individual.
- (d) RESTRICTION AGREEMENTS AND CONFIDENTIAL COMMUNICATIONS. Business Associate will comply with any agreement that Plan Sponsor/Covered Entity makes that either (i) restricts use or disclosure of Plan Sponsor/Covered Entity's Protected Health Information pursuant to 45 CFR § 164.522(a), or (ii) requires confidential communication about Plan Sponsor/Covered Entity's Protected Health Information pursuant to 45 CFR § 164.522(b), provided that Plan Sponsor/Covered Entity notifies Business Associate in writing of the restriction or confidential communication obligations that Business Associate must follow. Plan Sponsor/Covered Entity will promptly notify Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct Business Associate whether any of the Plan Sponsor/Covered Entity's Protected Health Information will remain subject to the terms of the restriction agreement. Effective February 17, 2010 (or such other date specified as the effective date by HHS), Business Associate will comply with any restriction request if: (i) except as otherwise required by law, the

disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Section V Breaches and Security Incidents

(a) REPORTING

(1) **Privacy or Security Breach.** Business Associate will report to Plan Sponsor/Covered Entity any use or disclosure of Plan Sponsor/Covered Entity's Protected Health Information not permitted by this Agreement along with any Breach of Covered Entity's Unsecured Protected Health Information. Business Associate will treat the Breach as being discovered in accordance with 45 CFR § 164.410. Business Associate will make the report to Plan Sponsor/Covered Entity's Privacy Official or representative not more than 15 calendar days after Business Associate learns of such non-permitted use or disclosure. If a delay is requested by a law-enforcement official in accordance with 45 CFR § 164.212, Business Associate may delay notifying Plan Sponsor/Covered Entity for the applicable time period. Business Associate's report will at least:

- Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;
- Identify Plan Sponsor/Covered Entity's Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information were involved) on an individual basis;
- Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
- Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;
- Identify what steps the individuals who were subject to a Breach should take to protect themselves;
- Provide such other information, including a written report, as Plan Sponsor/Covered Entity may reasonable request.

(b) **SECURITY INCIDENTS.** Business Associate will report to Plan Sponsor/Covered Entity any attempted or successful (i) unauthorized access, use, disclosure, modification, or destruction of Plan Sponsor/Covered Entity's Electronic Protected Health Information or (ii) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware. Business Associate will make this report once per month, except if any such security incident resulted in a disclosure not permitted by this Agreement or Breach of Plan Sponsor/Covered Entity's Unsecured Protected Health Information, Business Associate will make the report in accordance with the provisions set forth in the paragraph above.

Section VI Term and Termination

(a) **TERM.** The term of this agreement shall be effective as of February 17, 2010, and shall terminate when all Protected Health Information provided by Plan Sponsor/Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Plan Sponsor/Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

(b) **RIGHT TO TERMINATE FOR CAUSE.** Plan Sponsor/Covered Entity may terminate Agreement if it determines, in its sole discretion, that Business Associate has breached any

provision of this Agreement, and upon written notice to Business Associate of the breach, Business Associate fails to cure the breach within 30 calendar days after receipt of such notice. Any such termination will be effective immediately or at such other date specified in Plan Sponsor/Covered Entity's notice of termination.

- (1) Return or Destruction of Plan Sponsor/Covered Entity's Protected Health Information as Feasible. Upon termination or other conclusion of Agreement, Business Associate will, if feasible, return to Plan Sponsor/Covered Entity or destroy all of Plan Sponsor/Covered Entity's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of Plan Sponsor/Covered Entity's Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. Further, Business Associate shall require any such subcontractor or agent to certify to Business Associate that it returned to Business Associate (so that Business Associate may return it to the Plan Sponsor/Covered Entity) or destroyed all such information which could be returned or destroyed. Business Associate will complete these obligations as promptly as possible, but no later than 30 calendar days following the effective date of the termination or other conclusion of Agreement.
- (2) Procedure When Return or Destruction Is Not Feasible. Business Associate will identify any of Plan Sponsor/Covered Entity's Protected Health Information, including any that Business Associate has disclosed to subcontractors or agents as permitted under this Agreement, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. Business Associate will complete these obligations as promptly as possible, but no later than 30 calendar days following the effective date of the termination or other conclusion of Agreement.
- (3) Continuing Privacy and Security Obligation. Business Associate's obligation to protect the privacy and safeguard the security of Plan Sponsor/Covered Entity's Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

Section VII General Provisions

- (a) **DEFINITIONS.** All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations and other official government guidance.
- (b) **INSPECTION OF INTERNAL PRACTICES, BOOKS, AND RECORDS.** Business Associate will make its internal practices, books, and records relating to its use and disclosure of Plan Sponsor/Covered Entity's Protected Health Information available to Plan Sponsor/Covered Entity and to HHS to determine compliance with the Privacy Rule.
- (c) **AMENDMENT TO AGREEMENT.** Upon the compliance date of any final regulation or amendment to final regulation promulgated by HHS that affects Business Associate or Plan Sponsor/Covered Entity's obligations under this Agreement, this Agreement will automatically amend such that the obligations imposed on Business Associate or Plan Sponsor/Covered Entity remain in compliance with the final regulations or amendment to final regulation.
- (d) **NO THIRD-PARTY BENEFICIARIES.** Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.

(e) INTERPRETATION. Any ambiguity in the Agreement shall be resolved to permit Plan Sponsor/Covered Entity to comply with the applicable requirements under HIPAA.

PLAN SPONSOR

Name: STEVEN E. BROWN

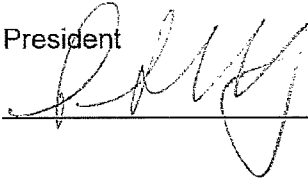
Title: ASSISTANT DIRECTOR HUMAN RESOURCES

Signature: 

TRI-STAR

Name: Stephen T. Hargrave

Title: President

Signature: 

**THE
METROPOLITAN ST. LOUIS
SEWER DISTRICT
FLEXIBLE BENEFIT PLAN**



**SUMMARY PLAN
DESCRIPTION**

Effective Date: August 1, 1989

Plan Year: February 1 to January 31

Plan Name: Metropolitan St. Louis Sewer District Flexible Benefit Plan

Plan Sponsor (Employer): Metropolitan St. Louis
and Plan Administrator Sewer District
2350 Market Street
St. Louis, MO 63103
(314) 768-6215

Service of legal process may be made upon the Plan Administrator.

Employer Identification Number: 43-6011991



TABLE OF CONTENTS

1. WHAT IS THE PURPOSE OF THIS PLAN?
2. WHO IS ELIGIBLE TO PARTICIPATE?
3. WHEN DO I ELECT TO MAKE CONTRIBUTIONS IN ORDER TO PURCHASE BENEFITS UNDER THE PLAN?
4. WHAT BENEFITS ARE AVAILABLE TO ME?
5. IF I ELECT TO REDUCE MY COMPENSATION UNDER THE PLAN, WILL I HAVE TO PAY ADDITIONAL TAXES AT THE END OF THE YEAR?
6. CAN I CHANGE MY ELECTION DURING A PLAN YEAR?
7. HOW DO I GET REIMBURSED FROM MY MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OR MY DEPENDENT CARE REIMBURSEMENT ACCOUNT?
8. WHAT IF MY CLAIM IS DENIED?
9. HOW WILL I KNOW HOW MUCH MONEY I HAVE IN MY MEDICAL EXPENSE REIMBURSEMENT OR DEPENDENT CARE REIMBURSEMENT ACCOUNT?
10. IF, AT THE END OF THE PLAN YEAR, THERE ARE AMOUNTS REMAINING IN MY MEDICAL EXPENSE REIMBURSEMENT OR DEPENDENT CARE REIMBURSEMENT ACCOUNT, WILL I GET THESE AMOUNTS BACK?
11. WHAT IF I AM ABSENT ON A FAMILY MEDICAL LEAVE?
12. WHAT IF I AM ABSENT FROM WORK FOR DUTY IN THE UNIFORMED SERVICES?
13. IF I TERMINATE PARTICIPATION IN THE PLAN, MAY I CONTINUE TO RECEIVE BENEFITS UNDER THE PLAN FOR THE REMAINDER OF THE PLAN YEAR?
14. WHO MAY AMEND OR TERMINATE THIS PLAN?
15. MAY I TRANSFER MY BENEFITS UNDER THE PLAN TO ANOTHER PERSON?
16. HOW IS THIS PLAN ADMINISTERED?
17. WHAT ELSE DO I NEED TO KNOW?

METROPOLITAN ST. LOUIS SEWER DISTRICT FLEXIBLE BENEFIT PLAN SUMMARY PLAN DESCRIPTION

1. WHAT IS THE PURPOSE OF THIS PLAN?

The Metropolitan St. Louis Sewer District Flexible Benefit Plan ("Plan") was developed to allow employees of Metropolitan St. Louis Sewer District to use before-tax earnings to purchase optional benefits under the Plan. The Plan enables employees to choose to pay for certain benefits with before-tax earnings. The Plan is effective August 1, 1989.

2. WHO IS ELIGIBLE TO PARTICIPATE?

You may participate in the Plan on the later of (1) the 30th day after the date you become an employee of the Employer, or (2) the date you complete a salary reduction agreement (see Question 3 below). You are not eligible to participate if (i) you are covered by a collective bargaining agreement that does not provide for coverage under the Plan, or (ii) you are an independent contractor.

3. WHEN DO I ELECT TO MAKE THE CONTRIBUTIONS IN ORDER TO PURCHASE BENEFITS UNDER THE PLAN?

Prior to the date of entering the Plan and prior to the beginning of each Plan Year, you will have the opportunity to elect to contribute (on a form furnished by the Employer) a portion of your compensation to pay for employee benefits.

You may elect to participate under the Plan as of the date on which you become eligible by completing a salary reduction agreement, a beneficiary designation form and an election of benefits form.

Employees who become eligible to participate in the middle of a Plan Year may elect to participate under the Plan for the remainder of that Plan Year provided the employee elects to participate no later than 30 days after becoming eligible to do so. If an election to participate is not made when you are first eligible to do so, you may nevertheless participate in the Plan in a subsequent Plan Year provided you elect to participate prior to the beginning of that subsequent Plan Year.

Your contributions will be made from your before-tax compensation. When you make your contributions from your before-tax compensation, you will reduce your compensation for tax purposes.

4. WHAT ARE THE BENEFITS AVAILABLE TO ME?

A participant may choose under this Plan to receive their full compensation for any Plan Year in cash or to have a portion of it applied by the Employer toward one or more of the following optional benefits:

(a) Group medical and dental plan costs paid by the employee.

(b) Medical Expense Reimbursement Account. You may elect to set aside a portion of your salary to pay for Medical Care Expenses not currently covered by health plan coverage with before-tax dollars. "Medical Care Expenses" include deductibles and co-payments, certain dental or orthodontic services, hearing and vision exam, eyeglasses and contact lenses (subject to such dollar limitation established by the Plan Administrator prior to the beginning of the Plan Year), prescription drugs, well baby care and physicals.

(c) Dependent Care Reimbursement Account. You may elect to set aside a portion of your salary to pay for Dependent Care Expenses. Dependent Care Expenses are those paid by you for the care of your children under 13 years of age who have the same principal place of abode as you for more than half of the calendar year, or other dependents who are not capable of care for themselves and who have the same principal place of abode as you for more than half of the calendar year.

You should be aware that the tax credit available for Dependent Care Expenses may be more advantageous for you. You should consult with a qualified tax counsel to determine the best option for you. Dependent Care Expenses excluded from your income under the Plan are not eligible for the tax credit.

"Dependent Care Expenses" means amounts paid or incurred by or on behalf of an employee for household services or for the care of a dependent, either inside or outside of the employee's home, in order to enable the employee to be gainfully employed for any period for which he or she has a dependent.

The amount of Dependent Care Expenses that can be reimbursed under the Plan for an employee during any year shall not exceed:

(a) In the case of an employee who is not married at the close of such year, the lesser of: \$5,000, or the earned income of such employee for such year.

(b) In the case of an employee who is married at the close of such year and who files a joint return with his or her spouse, the least of: \$5,000, the earned income of such employee for such year, or the earned income of the employee's spouse for such year.

(c) In the case of an employee who is married at the close of such year and files a separate return, the least of \$2,500, the earned income of such employee for such year, or the earned income of the employee's spouse for such year.

If the employee's spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to be gainfully employed and to have earned income of \$200 per month if the employee has only one dependent, and \$400 if the employee has two or more dependents.

For Dependent Care Expenses to be eligible for exclusion from gross income, the employee must report on his individual federal income tax return the correct name, address, and, in general, the taxpayer identification number of the dependent care provider.

The aggregate amount of salary that you may set aside during a Plan Year for reimbursement of Medical Care Expenses and Dependent Care Expenses may not exceed \$7500. The Dependent Care Expense limitation is explained above.

Contributions allocated to a particular benefit may never be used for any other benefit.

The Employer may elect to add, delete, or change any benefits under this Plan. Your participation under the Plan shall terminate when you leave the employment of the Employer. However, see Question 11 for your right to elect to continue participation in the Plan upon termination of employment pursuant to the health care continuation provision of section 4980B of the Internal Revenue Code. If you are reemployed after terminating participation, you are not allowed to make a new benefit election for the remaining portion of the Plan Year in which you previously terminated employment.

5. IF I ELECT TO REDUCE MY COMPENSATION UNDER THE PLAN, WILL I HAVE TO PAY ADDITIONAL TAXES AT THE END OF THE YEAR?

No. By using salary reduction to pay for optional benefits, the amount of compensation used to pay the cost of optional benefits is not subject to taxation. Therefore, the salary reduction will not cause the employee to owe any additional taxes at the end of the year. However, since your salary will be reduced, a smaller social security contribution will be made on your behalf. This may reduce your future social security benefits.

6. CAN I CHANGE MY ELECTION DURING A PLAN YEAR?

Generally, you cannot change or revoke your election during the Plan Year. You may change your election only if the revocation and new election results from a "change of status." A "change of status" includes a change in marital status, a change in the number of your dependents, a change in the employment status of you or your spouse (e.g., termination or commencement of employment, strike or lockout, commencement of, or return from, an unpaid leave of absence of you or your spouse, a change in worksite, switching from salaried to hourly or vice versa, a reduction or increase in hours of employment or any other similar change which makes you or your spouse

become (or cease to be) eligible for medical coverage), a change in residence, or an event that causes a dependent to cease to qualify for coverage as a dependent. A change in election under the Plan due to a change in status must be consistent with the change in status (e.g., a change to add dependent coverage due to the birth of a child). You may also change your election as a result of a significant change in the health coverage of you or your spouse, a significant change in the cost of health coverage of you or your spouse attributable to your spouse's employment, to comply with a qualified medical child support order in connection with a divorce, if you or your spouse or your dependent becomes entitled to Medical or Medicaid, or as permitted under the Family and Medical Leave Act (FMLA) or the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA)

Changes in elections are effective only for contributions and benefits following the effective date of such change. The effective date of the change or revocation shall be the date the event occurs provided a notice of such change or revocation is submitted to the Employer within 30 days of the event. Otherwise, such change or revocation shall be effective the date the notice is submitted.

Check with the Human Resources Department if you have questions about changing your election under the Plan.

7. **HOW DO I GET REIMBURSED FROM MY MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OR DEPENDENT CARE REIMBURSEMENT ACCOUNT?**

After you incur Medical Care Expenses or Dependent Care Expenses out of your own pocket, you must submit a claim on a form provided by your Employer.

Amounts held in your Medical Expense or Dependent Care Reimbursement Accounts may only be used for expenses incurred during the corresponding Plan Year in which such amounts are contributed. Expenses are considered incurred when the medical or dependent care is provided, not when billed, charged for or paid.

If you submit a claim for Dependent Care Expenses and, at that time, the claim exceeds the balance of your Dependent Care Reimbursement Account, the claim will be paid up to the amount in your Account. The remaining portion of the claim will be paid when and if further contributions are allocated, during the remaining portion of the Plan Year, to your Dependent Care Reimbursement Account.

With respect to reimbursement for Medical Care Expense, the aggregate amount of contributions to be allocated to your Medical Expense Reimbursement Account during the Plan Year (less any prior reimbursed claims for Medical Care Expenses during the Plan Year) shall be available for reimbursement at any time in a Plan Year even if it causes a negative balance in your Medical Expense Reimbursement Account. Any subsequent contributions made during the remaining portion of the Plan Year will be credited against such balance.

If the expense is covered by a medical plan or goes toward meeting the deductible, you must first submit the expense to the medical plan. You then submit a copy of the explanation of benefits statement from the insurance company, along with a claim form, to reimburse yourself for the expenses not covered by insurance.

If the expense is not eligible to be submitted to the medical plan, a copy of a bill, receipt, or other statement from an independent third party will serve as proof to substantiate your claim. Request for reimbursement shall include a written statement from you that the expenses have not been reimbursed or is not reimbursable under any other plan.

Claims for permissible expenses incurred during the Plan Year or the grace period described in Question 10 must be submitted no later than the June 15 following the end of such Plan Year, or such other date as may be specified by the Plan Administrator. All claims will be processed monthly.

The minimum payment amount for reimbursement checks is \$25.00. Claims of less than this amount may be submitted. However, no check will be mailed until additional claims are submitted which total \$25.00, the end of the Plan Year, or at any other time in the event of a final claim following termination of participation.

8. WHAT IF MY CLAIM IS DENIED?

If your claim for reimbursement is denied, in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered by the Metropolitan St. Louis Sewer District Employee Benefits Committee.

9. HOW WILL I KNOW HOW MUCH MONEY I HAVE IN MEDICAL EXPENSE REIMBURSEMENT OR DEPENDENT CARE REIMBURSEMENT ACCOUNT?

You will receive an Explanation of Benefits form attached to each reimbursement check you receive in payment for a claim. The Explanation of Benefits form will explain which expenses were paid and the remaining Account balance.

You will also receive Flexible Benefit Account Statements. These reports will include a detailed summary of all contributions, reimbursements and the current dollar balance in each Account in which you participate.

10. IF AT THE END OF THE PLAN YEAR, THERE ARE AMOUNTS REMAINING IN MY MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OR DEPENDENT CARE REIMBURSEMENT ACCOUNT, WILL I GET THESE AMOUNTS BACK?

If contributions to your Medical Expense Reimbursement Account exceed the claims for Medical Expenses incurred during the Plan Year, you may use the remaining balance of such Account to pay claims for Medical Expenses that are incurred during a

grace period ending on the April 15 immediately following the end of the Plan Year. If contributions to your Medical Expense Reimbursement Account exceed the claims for Medical Expenses incurred during the Plan Year and the grace period described above, such excess amounts will be forfeited.

If contributions to your Dependent Care Reimbursement Account exceed the claims for Dependent Care Expenses incurred during the Plan Year, such excess amounts will be forfeited.

You should plan your expenditures carefully and be conservative about Reimbursement Account elections to avoid forfeitures.

11. WHAT IF I AM ABSENT ON A FAMILY MEDICAL LEAVE?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) for a period totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage under the group medical and dental plans and the Medical Expense Reimbursement Account during your absence or to revoke your election of such coverage. If you maintain coverage under the group medical and dental plans and the Medical Expense Reimbursement Account, you must pay the contributions for such coverage during your absence using one of the two following methods:

- Prepayment. Under this option you may increase your salary reduction in an amount sufficient to cover the contributions that will come due during the FMLA leave.
- Pay-as-you-go. Under this option, you continue to pay on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the contributions will be paid with pretax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you will have to reimburse the Company at regular intervals from your after-tax funds for the contributions that come due during the leave.

12. WHAT IF I AM ABSENT FROM WORK FOR DUTY IN THE UNIFORMED SERVICES?

Your right to continue coverage under the group medical and dental plans and the Medical Expense Reimbursement Account during leaves of absence for active military duty is protected by the Uniformed Service Employment and Reemployment Rights Act (USERRA). If you are eligible, continued coverage is equal to, and subject to the same limitations as, the benefits provided to other Members participating in this Plan. The continued coverage under the Plan is available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your contribution for continued coverage is the same as for other Members plus the Employer can charge a 2% administrative fee.

13. IF I TERMINATED PARTICIPATION IN THE PLAN, MAY I CONTINUE TO RECEIVE BENEFITS UNDER THE PLAN FOR THE REMAINDER OF THE PLAN YEAR?

Upon termination of participation, you (or your designated beneficiary in the case of your death) may only receive benefits under the Plan for expenses incurred prior to your termination date. You will, however, be able to file claims after your termination date for expenses incurred before that date. In addition, upon termination of employment, you will not be eligible to make contributions to the Plan unless you elect to do so under the health care continuation provisions of section 4980B of the Internal Revenue Code.

14. WHO MAY AMEND OR TERMINATE THIS PLAN?

The Employer may amend or terminate the Plan. If the Plan is terminated, you and the Employer will have only the financial obligations that have accrued up to the date of termination.

15. MAY I TRANSFER MY BENEFITS UNDER THE PLAN TO ANOTHER PERSON?

No. You may not transfer, sell, assign, pledge, attach, encumber, or subject, in any manner, a benefit under the Plan.

16. HOW IS THE PLAN ADMINISTERED?

This Plan is administered by Metropolitan St. Louis Sewer District.

17. WHAT ELSE DO I NEED TO KNOW?

The previous questions and answers are intended to give you a brief description of the major provisions of the Plan. The Plan is a lengthy legal document which includes these provisions and numerous others. In the event of any inconsistency between this description and the actual provisions of the Plan, those in the Plan will govern.

If you should have any questions regarding the Plan or would like further information about the Plan, contact the Plan Administrator either in writing or by telephone.