# ATTACHMENT B

**THE COUNTY OF MONTEREY**
**SECTION 125 FLEXIBLE BENEFIT PLAN**

AMENDED AND RESTATED
PLAN DOCUMENT

As Adopted By
The County of Monterey
Effective July 1, 2014

The County of Monterey
Section 125 Flexible Benefits Plan

# 1. INTRODUCTION

## 1.1 PURPOSE OF PLAN.

The purpose of this Plan is to provide Eligible Employees of the County a choice between cash and the non-taxable benefits under Section 5 and amends and restates in a single document as of January 1, 2012, the County of Monterey Section 125 Flexible Benefit Plan, originally effective January 1, 2000, the County of Monterey Alternative Benefit Option (ABO) Account Section 125 Flexible Benefit Plan, originally effective January 1, 2002, and the County of Monterey Section 105 Flexible Spending Plan, effective July 1, 2014.

## 1.2 INTENTION OF PLAN.

The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code as amended from time to time. This Plan is intended to be maintained for the exclusive benefit of Eligible Employees, their Spouses, Dependents and beneficiaries. The Dependent Care Assistance Plan is intended to qualify as a Code Section 129 dependent care assistance plan. Although reprinted within this document, the Dependent Care Assistance Plan is a separate written plan for purposes of administration and all reporting and nondiscrimination requirements imposed by the Code and other applicable law. The Health Flexible Spending Account is intended to qualify as a Code Section 105 health flexible spending account plan. Although reprinted within this document, the Health Flexible Spending Account is a separate written plan for purposes of administration and all reporting and nondiscrimination requirements imposed by the Code and other applicable law.

## 2. DEFINITIONS

The following words and phrases are used in this Plan and will have the meanings set forth unless a different meaning is clearly required by the context.

### 2. 1 ADMINISTRATOR.

The County's Human Resource Director, with primary responsibility for human resource matters, or his or her delegate, as more fully defined in Article 8, except as otherwise specified in a Benefit Plan or Policy with respect to such Benefit Plan or Policy.

### 2.2 ALTERNATIVE BENEFIT OPTION (ABO).

The program that allows for reimbursement to a Participant of individually owned, private, primary medical (excluding stand alone vision and dental) insurance policy premiums in accordance with the terms of this Plan and Prop. Regs. § 1.125-1(m) or successor provisions. Reimbursement may be made in the following instances:

(a) Coverage on a pre-tax basis of the Participant and optionally his or her spouse and/or Dependent(s) under a private, primary medical policy from a third party insurer.

(b) Coverage on an after-tax basis of the Participant and optionally his or her spouse and/or Dependent(s) under the Participant's prior employer's medical plan, including under COBRA. A Participant electing after-tax coverage is treated for reporting, withholding and other Code purposes, as receiving cash compensation and purchasing the coverage with after-tax employee contributions.

(c) Coverage on a pre-tax basis of the Participant's Spouse and optionally the Participant and/or the Participant's Dependent(s) under a private, primary medical policy from a third party insurer.

(d) Coverage on an after-tax basis of the Participant's Spouse and optionally the Eligible Employee and/or the Participant's Dependent(s) under the Spouse's current or prior employer's medical plan, including under COBRA. A Participant electing after-tax coverage is treated for reporting, withholding and other Code purposes, as receiving cash compensation and purchasing the coverage with after-tax employee contributions.

In no case will reimbursement be made for any public employees' retirement system plan or program in California or any other state, no matter how or where such coverage is acquired.

### 2.3 BENEFIT PLAN(S) OR POLICY(IES).

The employee benefit plan(s) and policies pursuant to which Qualified Benefits are provided.

### 2.4 BENEFIT OPTIONS.

Each type of Qualified Benefit available for election by an Eligible Employee under Section 5 below, including medical (including the Alternative Benefit Option program), vision, dental, Dependent Care Assistance Plan and Health Flexible Spending Account Plan.

### 2.5 BOARD OR BOARD OF SUPERVISORS.

Board of Supervisors or Board shall mean the Monterey County Board of Supervisors.

### 2.6 CHANGES IN STATUS.

Any of the events described below, to the extent determined by the Administrator to be permitted under Code Section 125, as well as any other events which the Administrator (in its sole discretion) determines are permitted under subsequent changes to Code Section 125 or regulations issued under Code Section 125:

(a) *Legal Marital Status.* A change in an Eligible Employee's legal marital status as defined for Federal law purposes, including marriage, death of a Spouse, divorce, legal separation or annulment, in addition to corresponding changes in a Domestic Partnership or state law marriage of same gender spouses;

(b) *Change in Number of Tax Dependents.* A change in the Eligible Employee's number of Dependents, including the birth of a child, the adoption or placement for adoption of a Dependent, or the death of a Dependent;

(c) *Change in Employment Status.* Any change in employment status of the Participant, the Participant's Spouse or the Participant's Dependents that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan (including the Benefit Plan(s) or Policy(ies)) of the employer of the Participant, the Spouse, or Dependents. Such events include any of the following: changes in the employment status of the Participant, the Participant's Spouse or the Participant's Dependent's termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

(d) *Dependent Eligibility Requirements.* An event that causes a Participant's Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age or otherwise;

(e) *Change in Residence.* A change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependent that affects benefits eligibility or coverage.

For Dependent Care Assistance and Health Flexible Spending Account benefits, Change in Status means all of the events described above, and in addition such other events as may be described by the Internal Revenue Service from time to time as a Change in Status with respect to such benefits.

2.7 COBRA.

Continuation coverage as described in Section 3.7.

2.8 CODE.

The Internal Revenue Code of 1986, as amended from time to time.

2.9 COMPENSATION.

The base pay paid to an Employee by the County, prior to deduction for other purposes such as elective contributions to a Code section 457 or other plan.

2.10 CONTRIBUTIONS.

Amounts specified under the Participant's Enrollment Flex Form.

2.11 COUNTY.

County shall mean the County of Monterey.

2.12 DEPENDENT.

Any of the following, to the extent otherwise permitted in accordance with the applicable Benefit Plans and Policies:

(a) Any child (as defined in Code section 152(f)(1)) of a Participant until the end of the month in which the child attains age 26;

(b) Any individual who is a tax dependent of a Participant as defined and permitted by the Code for purposes of this Plan, or

(c) Any individual who is determined to be an alternate recipient of a Participant under an order determined to be a qualified medical child support order ('QMCSO'') by the Administrator.

A same gender domestic partner, a same gender spouse, or an opposite gender domestic partner where either the Participant or domestic partner is over the age of 62, who does not qualify as a "spouse" under the Defense of Marriage Act may be a "Dependent" under this Plan, but only if registered as a domestic partner for state law purposes or legally married under applicable state law, and only to the extent permitted under the applicable Benefit Plans and Policies. In addition, to the extent permitted under applicable Benefit Plans and Policies, such domestic partner's, or same gender spouse's dependents shall constitute "Dependents" of the Participant to the extent they would qualify under these rules if the domestic partner were a Participant. To the extent a domestic partner, a same gender spouse or his or her dependents, is a "Dependent' under applicable Benefit Plans and Policies but not a "spouse" under the Defense of Marriage Act or a Dependent under applicable Code sections, his or her participation as a "Dependent' under this Plan shall be on an after-tax basis. The Participant electing such after-tax coverage is treated for reporting, withholding and other Code purposes, as receiving cash compensation and purchasing the coverage with after-tax employee contributions.

2.13 DEPENDENT CARE ASSISTANCE PLAN.

The Dependent Care Assistance program described in Appendix A and intended to qualify under Internal Revenue Code Section 129.

2.14 HEALTH FLEXIBLE SPENDING ACCOUNT

The Health Flexible Spending Account program as described in Appendix C and intended to qualify under Internal Revenue Code Section 105.

2.15 ELECTION PERIOD.

The period, as determined by the Administrator, taking into account applicable provider requirements, preceding the start of each Plan Year, during which Eligible Employees are permitted to make contribution and coverage elections for the next Plan Year in accordance with the Administrator's rules and procedures.

2.16 ELIGIBLE EMPLOYEE.

An Employee who has satisfied the Eligibility Requirements.

2.17 ELIGIBLITY REQUIREMENTS.

Those requirements, set forth below are the minimum conditions necessary to be able to participate in the Plan, other than the Dependent Care Assistance Plan. A participant must:

(a) Be an Employee of the County;

(b) Be scheduled to regularly work a minimum of twenty (20) hours per week and be paid on a United States payroll;

(c) Have met any service or other eligibility requirement of the underlying Benefits Plans and Policies: such requirements being incorporated by reference.

The above eligibility requirements of this Section are modified to the extent provided in the Flex Credit and Flex Dollar Rate Sheet attached as Appendix B and in the Benefit Plans or Policies.

The eligibility requirements for the Dependent Care Assistance Plan are as provided in Appendix A.

The eligibility requirements for the Health Flexible Spending Account Plan are as provided in Appendix C.

2.18 EMPLOYEE.

Any individual who is treated by the County as a common law employee of the County for Federal reporting and withholding tax purposes. The term Employee does not include any person whom the County treats as a non-Employee, even if a court, tribunal, or administrative agency determines that the person is a common law employee (including, for example, independent contractors, contract labor, consultants or advisers, leased employees (as that terms is defined in Code Section 414(n)), self-employed individuals, directors and any person whose services are not paid directly through the payroll department). The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as necessary to comply with applicable laws and regulations and as provided hereunder in which an employee ceases to be employed by the County, provided the component Benefit Plan or Policy allows for such continuation and any required contributions are made.

2.19 ENROLLMENT FLEX FORM.

Agreement, written or electronic, whereby the Eligible Employee participates by entering into a Salary Reduction Agreement so as to receive selected benefits under Section 5 below. The Enrollment Flex Form, including the Salary Reduction Agreement, may be changed by the Administrator at any time.

2.20 ENTRY DATE.

The date that the Employee actually commences participation in the Plan after the Eligibility Requirements have been met and pursuant to the rules and procedures of the Administrator.

2.21 INDIVIDUAL COVERAGE ACCOUNT.

The sub-accounts described in Section 6.1 herein. These sub-accounts cover the Dependent Care Assistance Plan and Alternative Benefit Option Accounts available to participants.

2.22 INSURER.

Any insurance company that has issued a Policy.

2.23 PARTICIPANT.

Any Eligible Employee participating in the Plan in accordance with Section 3 below.

2.24 PARTICIPANT ACCOUNT.

The account described in Section 6.1 herein.

2.25 PLAN.

The County of Monterey Section 125 Flexible Benefits Plan as set forth herein, together with any and all documents incorporated by reference including amendments and supplements hereto.

2.26 PLAN YEAR.

The Plan Year is the calendar year, starting January 1 and ending December 31. The Health Flexible Spending Account will begin on July 1, 2014 and end on December 31, 2014, thereafter, the Plan Year will begin on January 1 and end on December 31.

2.27 POLICY.

Any insurance policy pursuant to which Qualified Benefits are provided.

2.28 QUALIFIED BENEFITS.

Those benefits described in Section 5, including but not limited to the Alternative Benefit Option program and the Dependent Care Assistance Plan.

2.29 REIMBURSABLE EXPENSE.

Any out-of-pocket expense of a Participant that qualifies for reimbursement under the Alternative Benefit Option program or Dependent Care Assistance Plan.

2.30 SALARY REDUCTION AGREEMENT.

The portion of the Eligible Employee's Enrollment Flex Form whereby the Eligible Employee elects to reduce and/or deduct from the Employee's Compensation so as to receive selected benefits under Section 5 below.

2.31 SPOUSE.

An individual who is legally married to a Participant and who is treated as a spouse under the Code.

2.32 STUDENT.

An individual who is a student within the meaning of Code Section 152(f)(2).

# 3. ELIGIBILITY AND PARTICIPATION

## 3.1 ELIGIBILITY REQUIREMENTS.

Each Employee who has satisfied the Eligibility Requirements is eligible to participate in the Plan on his or her Entry Date. An Eligible Employee will become a Participant by electing at least one Qualified Benefit each Plan Year under either Section 4.4, 4.5 or 4.6 below, as applicable. Eligibility for benefits is subject to the additional requirements, if any, specified in the applicable Benefit Plan or Policy. The provisions of this plan do not override, limit or otherwise modify in any way any exclusion, eligibility requirement(s), waiting period(s), or other condition or limitation specified in the applicable Benefit Plans or Policies.

## 3.2 PARTICIPATION TERMINATION.

A Participant will cease to be a Participant as of the earlier of:

(a) The date the Plan terminates.

(b) The date the Participant ceases to be an Eligible Employee (except to the extent provided in Section 3.7 for COBRA continuation);

(c) The first day of the subsequent Plan Year if the Participant waives or terminates participation under Section 4.4 below; or

(d) The date of the Participant's termination of employment.

## 3.3 LEAVE OF ABSENCE.

Subject to any specific limitations for any particular benefit which the Employee has elected:

(a) Participation will be continued during a leave of absence for which the Employee continues to receive a salary from the County to the extent provided in applicable memoranda of understanding with collective bargaining units or the County's Personnel Policies and Procedures Resolution; and

(b) Except as provided in paragraph 3.3(c), Section 3.4 or an applicable Appendix, if any, participation will be suspended during an unpaid leave of absence.

(c) Any employee on a military leave of absence that is protected under the Uniformed Services Employment and Reemployment Rights Act is entitled to elect, after the cessation of any County provided salary continuation, continued participation on an after-tax basis in accordance with the rules and procedures of the County and subject to the provisions and limitations of the applicable Benefit Plan or Policy. Such coverage shall commence immediately after the cessation of any County provided salary continuation and shall continue for the lesser of twenty-four months or the duration of the qualifying military leave. After the first 30 days, the employee shall pay 102% of the full premium or other cost of the continued coverage(s).

## 3.4 QUALIFIED LEAVE UNDER FAMILY AND MEDICAL LEAVE ACT AND WORKERS COMPENSATION

Notwithstanding any provision to the contrary in this Plan, if an Employee goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), or is receiving temporary disability payments as a result of an approved workers compensation claim, the County will continue to maintain the Employee's medical, dental and vision plan benefits on the same terms and conditions as though he or she were still an active Employee (i.e., the County will continue to pay its share of the premium to the extent the Employee opts to continue his coverage). No taxable cash or other contributions will be made to or on behalf of such employee, including but not limited to ceasing contributions to the Employee's Alternative Benefit Option program or Dependent Care Assistance Plan during the leave.

Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave or as otherwise required by the FMLA or applicable law.

3.5 REINSTATEMENT OF FORMER PARTICIPANT.

A former Participant may become a Participant again if and when the Eligibility Requirements of Section 3.1 above are met. Except as provided below, if revocation occurs under Section 3.2(d), no new election with respect to Contributions may be made by such Participant during the remainder of such Plan Year. Except as otherwise provided in the applicable Benefit Plans or Policies, former Participants who are rehired within 30 days or less of the date of termination of employment will be reinstated with the same election(s) such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election in accordance with the Change in Status rules.

3.6 EMPLOYEE MUST WAIT UNTIL SUBSEQUENT YEAR.

If an Eligible Employee fails to elect to participate in accordance with the election procedure cited in either Section 4.4, 4.5 or 4.6 below, as applicable, that Employee may become a Participant in any subsequent Plan Year in which he or she continues to be an Eligible Employee, but not before that time, except as provided in Section 4.8.

3.7 CONTINUATION OF COVERAGE.

Pursuant to Section 4980B of the Code, any qualified beneficiary (as defined in Section 4980B(g)(1) of the Code), who would lose health coverage under a group health plan as a result of a qualifying event (all as defined in Section 4980B of the Code) can elect, within a stated election period, continuation coverage of benefits previously received under the Plan.

**COBRA applicability Health Flexible Spending Account:** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 10.13 of the Plan.

3.8 WORKING SPOUSE RULE.

If a husband and wife are both Eligible Employees under the Plan, they have the following enrollment options with respect to each Benefit Option as defined in Section 2.4:

(a) Each may enroll separately, with neither claiming the other as a dependent. Both husband and wife will be entitled to any County-provided flex credits or credit dollars otherwise available to him or her as an Eligible Employee under the Plan.

(b) Either (but not both) the husband or wife may enroll, claiming the other as his or her dependent. The enrolling spouse will be entitled to any County-provided flex credits or credit dollars otherwise available to him or her as an Eligible Employee under the Plan but no flex credits or credit dollars will be provided to, or on behalf of, the dependent spouse.

In no case may an individual be enrolled as both a Participant and as the dependent of another Participant in any Benefit Option that is available to Eligible Employees and pursuant to which the County provides flex credits or credit dollars. In no case may any individual be enrolled as a dependent of more than one Participant in any Benefit Option that is available to Eligible Employees and pursuant to which the County provides flex credits or credit dollars.

# 4. ELECTION OF BENEFITS

## 4.1 ELECTION OF BENEFITS.

To become a Participant, an Eligible Employee must timely elect under this Plan to receive one or more of the benefits referenced in Section 5 below. Any such election must be made in accordance with all rules, procedures and any applications or agreements as may be required by the Administrator.

## 4.2 CONTRIBUTIONS FOR ELECTED QUALIFIED BENEFITS.

The Participant will irrevocably agree, except as otherwise provided in this Article 4, to reduce the Participant's cash Compensation by such amounts as are necessary to provide for the elected Qualified Benefits for the applicable Plan Year. These amounts will then be contributed by the County on the Employee's behalf as County contributions.

## 4.3 CONTRIBUTION ADJUSTMENTS.

If the premium costs for any of the Qualified Benefits change during the Plan Year, the County will make corresponding adjustments, on a reasonable and consistent basis, in the payroll reductions and/or deductions in accordance with the provisions of the Plan and the Enrollment Flex Form signed by the Participant.

## 4.4 ELECTION PROCEDURES FOR RENEWALS.

During open enrollment in advance of each Plan Year, the Administrator will supply each Eligible Employee an Enrollment Flex Form with which the Eligible Employee can elect to participate, terminate participation in the Plan or change Qualified Benefits. If the Eligible Employee chooses to take one of these actions, the Enrollment Flex Form must be completed and returned to the Administrator on or before such date as the Administrator will specify. Elections may be offered under the Plan at different times for different Qualified Benefits.

## 4.5 ELECTION PROCEDURES FOR NEW HIRES

Newly hired Eligible Employees may complete the Enrollment Flex Form with the effective date as the prospective date on which the Eligible Employee subsequently satisfies the Eligibility Requirements. Notwithstanding the prior sentence, new hires may elect to participate as of their hire date, with respect to Compensation not yet available as of their election date, so long as they satisfy the Eligibility Requirements and complete the Enrollment Flex Form within 30 days of their hire date.

## 4.6 FAILURE TO ELECT.

An Eligible Employee who is a Participant in the Plan and who fails to return an Enrollment Flex Form to the Administrator on or before the specified due date, will be deemed to have elected to perpetuate his or her prior Plan Year elections, except for Alternative Benefit Option and Dependent Care Assistance Program coverage. Annual elections for participation in the Alternative Benefit Option programs and Dependent Care Assistance Plan for a Plan Year must be made by submitting an Enrollment Flex Form electing such benefits during the Election Period for such Plan Year. An Eligible Employee, either as a new hire or upon open enrollment, who is not a current Participant in the Plan and who fails to return an Enrollment Flex Form to the Administrator on or before the specified due date, will be deemed to have elected to not participate in the Plan. Any Participant who is deemed to have made an election will also be deemed to have agreed to a reduction in his or her Compensation for the subsequent Plan Year equal to the Participant's share of the cost of such benefit.

## 4.7 CHANGES BY ADMINISTRATOR.

If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits, or other Code or legal requirements, the Administrator will take such action as the Administrator deems appropriate under 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 and/or key employees (all as defined in applicable Code Sections) with or without the consent of such Employees.

4.8 REVOCATION OF ELECTIONS.

Except as provided in Section 4.4, a Participant shall not make any changes to the contribution amount elected under the Plan, except as provided herein:

(a) *Change in Status.* A Participant may change or terminate his or her actual or deemed election under this Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status which affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent. The Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in status.

Assuming the general consistency requirement of the prior paragraph is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on that change:

(1) *Loss of Dependent Eligibility.* For a Change in Status involving a Participant's divorce, annulment, legal separation, or cessation of domestic partnership from a Spouse, covered domestic partner or same gender spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for the Spouse, covered domestic partner or same gender spouse involved in the divorce, annulment, legal separation, or cessation of domestic partnership, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease coverage for that individual only if coverage for that individual becomes effective under the other employer's plan.

(3) *Dependent Care Assistance Plan benefits.* With respect to the Dependent Care Assistance Plan, a Participant may change or terminate his or her election only if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusions available under Code Section 129.

(b) *Special HIPAA Enrollment Rights.* A Participant may change an election for health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights as required by Section 9801(f) of the Code, including those under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009; provided such Participant satisfies the sixty (60) day notice requirement imposed by Code Section 9801(f). Such election shall be prospective except in the case of a HIPAA special enrollment election attributable to the birth or adoption of a new Dependent child which may, subject to the rules and provisions of the underlying group health plans, be effective retroactively.

(c) *Certain judgments, decrees and orders.* If a judgment decree or order (an "Order") resulting from a divorce, legal separation, annulment, change in legal custody (including a qualified medical child support order), or similar occurrence requires accident or health coverage for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may i) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage) or ii) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's spouse, domestic partner or former spouse or former domestic partner) provide coverage under that individual's plan.

(d) *Medicare and Medicaid*. If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the health or accident coverage of the individual.

(e) *Change in Cost*

The following rules are not applicable to the Alternative Benefit Option program under the Plan. No mid-Plan Year election change is permitted with respect to the Alternative Benefit Option program.

(1) *Automatic increase or decrease in salary reduction contributions for insignificant cost changes*. Pursuant to Section 4.3 of the Plan, Participants are required to increase or decrease their salary reduction contributions to reflect insignificant increases or decreases in the cost of Benefit Plan(s) or Policy(ies) provided under the Plan. The Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in affected Employees' salary reduction contributions in accordance with such cost changes. The Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change.

(2) *Significant cost increases*. If the Administrator determines that the cost of a Participant's Benefit Plan(s) or Policy(ies) significantly increases during a Plan Year, the Participant may either make a corresponding prospective increase in his or her salary reduction contributions, or revoke his or her election, and in lieu thereof, elect coverage under another Plan option, if any, which provides similar coverage. If similar coverage is not offered under the Plan, the participant may drop the election. The Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant, and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) *Limitation on Change in Cost provisions for Dependent Care Assistance accounts*. The above "Change in Cost" provisions (Sections 4.8(e)(l) and 4.8(e) (2)) apply to Dependent Care Assistance reimbursement only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee as defined in Code section 129.

(f) *Change in Coverage*

The following rules are not applicable to the Alternative Benefit Option program under the Plan. No mid-Plan Year election change is permitted with respect to the Alternative Benefit Option program.

(1) *Significant Curtailment.* If the Administrator determines that a Participant's Benefit Plan or Policy coverage under this Plan is significantly curtailed or ceases during a Plan Year, the Participant may revoke his or her election under the Plan. In that case, each affected Participant may prospectively elect coverage under another Benefit Plan or Policy option, if any, which provides similar coverage. If similar coverage is not offered under the Plan, the Participant may drop the election. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant", and whether a substitute Benefit Plan or Policy constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) *Addition or elimination of benefit package option providing similar coverage.* If during a Plan Year the Plan adds, substantially improves, or eliminates a Benefit Plan or Policy, an affected Participant may elect a newly-added option or elect another Benefit Plan or policy (where a Plan option has been eliminated), and may do so prospectively on a pre-tax basis, if applicable, by making corresponding

election changes with respect to coverage under another Benefit Plan or Policy option, if any, which provides similar coverage. If a Benefit Plan or Policy is eliminated and similar coverage is not offered under the Plan, the Participant may drop the election. The Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a substitute Benefit Plan or Policy constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) *Change in coverage of Spouse or Dependent under their employer's plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer, so long as (a) the cafeteria plan or qualified benefits plan of the Spouse's, or Dependent's employer permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year period of coverage which is different from the plan year period of coverage under the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's or Dependent's employer. The Administrator (in its sole discretion) may request and require from the Participant any information, other plan documents or materials and statements the Administrator desires and shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer.

No Participant shall be allowed to reduce his or her election for dependent care reimbursement benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed. In addition any change in an election affecting annual Plan Contributions to the Dependent Care Assistance Plan pursuant to this Section also will change the "Maximum Reimbursement Benefits" for the period of coverage remaining in the Plan Year. Such Maximum Reimbursement Benefits for the period of coverage following an election change shall be calculated by adding the balance (if any) remaining in the Participant's Reimbursement Account as of the end of the portion of the Plan Year immediately preceding the change in election, to the total Plan Contributions scheduled to be made by the Participant during the remainder of such Plan Year to such Account.

An Employee who is eligible to become a Participant but declined to become a Participant during the initial Election Period may become a Participant and submit an Enrollment Flex Form within thirty (30) days of the occurrence of an event described in Section 4.8(a) above, but only if the election under the new Enrollment Flex Form is made on account of and corresponds with the event (as described above) (e.g., birth of Dependent, change to add such Dependent). A Participant otherwise entitled to make a new election under this Section must do so within 30 days of the event (e.g. Change in Status, significant change in cost or coverage, Medicare or Medicaid eligibility, special enrollment right or judgment, decree, or order). Subject to the provisions of the underlying group health plan and applicable law, elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive at any time. All other new elections shall be effective no sooner than the first day of the month immediately following the date the Participant timely and properly files his new Enrollment Flex Form with the Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

4.9 AUTOMATIC TERMINATION OF ELECTIONS.

Elections made under this Plan (or deemed to be made under Section 4.6 above) will automatically terminate on the day the Participant ceases to be a Participant in the Plan although any coverage provided by the underlying Benefit Plans may continue if and to the extent provided under such Benefit Plans.

4.10 MAXIMUM ELECTIVE CONTRIBUTIONS.

The maximum amount of salary reduction contributions under the Plan for any Participant shall be the total cost to the Participant, in the form of salary reduction, for the Plan Year of the most expensive Qualified Benefits that any Participant could elect in accordance with their specific bargaining unit, the underlying Benefit Plan or Policy, enrollment materials and other Plan instruments.

## 5. PLAN BENEFITS

Payment will be made to the Participant, the appropriate Insurer or Benefit Plan for coverage of the Participant or the Participant's Spouse or Dependents under the Policy or Benefit Plan as set out below. Subject to the Section 3.8 working spouse and other rules in this Plan, each Participant will have the right to select that portion of the Participant's available benefit funds to be used to provide such benefit.

The actual terms, conditions and limitations of each of the Qualified Benefits described below are contained in the official plan documents for each of the Qualified Benefits. As more fully described in Section 12.13 of this Plan, in the event of a conflict between this Plan and the documents governing the substantive benefit plans, such other document(s) shall control.

Subject to the provisions of Article 4, an Eligible Employee may elect to have the County, on behalf of the Eligible Employee as authorized by the Eligible Employee's individual Enrollment Flex Form, provide contributions for the following benefits:

Dental through Pacific Health Alliance
Vision Service Plan
PERSChoice
PERSCare
PERSelect
Blue Shield Advantage
Blue Shield
Blue Shield Net Value
Kaiser
PORAC (Police Officers Retirement Association)
Dependent Care Assistance Plan
Alternative Benefit Option program
Health Flexible Spending Account Plan

From time to time, the County also may offer other benefits, which may include universal or term life, long-term care, AD&D, disability, cancer, heart and stroke, spouse or dependent life insurance and other benefits that are paid with employee after-tax contributions. These other benefits are not part of this Plan but are provided by the County under a separate arrangement. That separate arrangement may be administered in accordance with rules and procedures like those of this Plan but is not part of this Plan.

## 6. PARTICIPANT BENEFIT ACCOUNTS

### 6.1 PROVISION FOR PARTICIPANT ACCOUNTS.

The Administrator will maintain a Participant Account for each Participant. The Participant Account may have assigned an "Individual Coverage Account," to the extent applicable.

### 6.2 CREDITING PARTICIPANT ACCOUNTS.

Amounts will be credited to the Participant Account in accordance with
Section 7.1 and may be allocated to the Individual Coverage Accounts in accordance with Section 7.2.

### 6.3 DEBITING PARTICIPANT ACCOUNTS.

Amounts will be debited in accordance with Section 7.

### 6.4 NATURE OF PARTICIPANT ACCOUNTS.

No money will actually be allocated to any Participant Account or Individual Coverage Accounts. Any such Account will be of a memorandum nature, maintained for accounting purposes, and will not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account or any Coverage Accounts.

## 7. BENEFIT FUNDING AND CREDITS/DEBITS TO ACCOUNTS

### 7.1 SOURCE OF CREDITS TO PARTICIPANT ACCOUNTS.

The cost of coverage under the component Benefit Plans or Policies shall be funded by the Participant Enrollment Flex Form amounts. The County will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible. The component Benefit Plans or Policies, and required contributions thereunder, shall be made known to Employees in enrollment materials and set forth on an annual schedule in the enrollment materials.

The County shall withhold from a Participant's Compensation on a pre-tax or, to the extent otherwise provided in the Plan, on an after-tax basis, an amount equal to the contributions required from the Participant for coverage of the Participant or the Participant's Spouse or Dependents, under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as pre-tax Contributions or after-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of pre-tax Contributions shall not exceed the aggregate cost of the benefits elected. A Participant electing after-tax coverage is treated for reporting, withholding and other Code purposes, as receiving cash compensation and purchasing the coverage with after-tax employee contributions.

A Participant shall have his or her wages reduced by the amount necessary to pay the employee portion of the premiums or contributions for coverage under these Benefit Plan(s) and Policy(ies), unless the Participant notifies the County in writing that (s)he does not want the premium or contribution to be made on a pre-tax basis. However, no amounts will be credited to Alternative Benefit Option or Dependent Care Assistance Account unless the Participant timely specifies an amount on a Salary Redirection Agreement form.

The County also may contribute flex credits for a Participant. In addition, the County may contribute credit dollars towards the purchase of Alternative Benefit Option program benefits. The amount of, and terms of, County provided flex credits, if any, or credit dollars, if any, that are available to any Participant shall be set forth on the Flex Credit and Flex Dollar Rate Sheet that is attached as Appendix B of this Plan. The Flex Credit and Flex Dollar Rate Sheet shall be determined and updated based upon memoranda of understanding with collective bargaining units and the County's Personnel Policies and Procedures Resolution, as applicable.

### 7.2 ALLOCATIONS TO PARTICIPANT'S INDIVIDUAL COVERAGE ACCOUNTS.

Amounts will be allocated, on the date credited to the respective Individual Coverage Accounts of the Participant, pursuant to the elections made by the Participant in accordance with Section 4. All applicable payments of benefits and other qualifying amounts, if any, will be debited against the appropriate Individual Coverage Account.

### 7.3 ALLOCATIONS IRREVOCABLE DURING PLAN YEAR.

Except as provided in Section 4.8, neither (a) the amounts to be credited to a Participant Account during a Plan Year pursuant to Section 7.1, nor (b) the allocation of such amounts to the appropriate Individual Coverage Accounts of a Participant pursuant to Section 7.2 can be changed during the Plan Year.

### 7.4 FORFEITURE OF UNUSED ACCOUNT BALANCES.

Any amount allocated to an Individual Coverage Account will be forfeited by the Participant if it has not (a) been applied to provide the elected Benefit before December 31 of the Plan Year for which the Participant's election was made and (b) timely submitted for reimbursement in accordance with the Administrator's rules. Participant forfeitures from the Dependent Care Assistance Plan will be processed pursuant to Appendix A, Section 4.4. Participant forfeitures from the Alternative Benefit Option Individual Coverage Account will be processed in accordance with rules comparable to those for Dependent Care Assistance Plan in Appendix A, Section 4.4.

7.5 ADJUST ELECTIONS TO PREVENT DISCRIMINATION.

The Administrator will have the power to reduce or revoke any Employee's Enrollment Flex Form with respect to benefits hereunder at any point before or during the Plan Year if such reduction or revocation is necessary to prevent the Plan from becoming discriminatory.

7.6 ADJUST ELECTIONS DUE TO PREMIUM CHANGES.

The Administrator may automatically increase or decrease the amount of a Participant's salary reduction during the Plan Year in response to a change in the premiums charged by an Insurer for any of the insured benefits elected hereunder, commensurate with the time that the Insurer has made such premium change effective.

If the Administrator determines a cost increase to be significant, the Administrator will notify the Participants before changing the premiums and inform the Participants of their permitted actions as set forth under Section 4.8 above. Unless the Participant is entitled to and makes a change of election under Section 4.8 above, the adjusted salary reduction amount will be in effect until the end of the Plan Year coverage period, a subsequent change in premiums required by the Insurer, or by another Insurer providing substituted coverage during the Plan Year.

7.7 ADJUST ELECTIONS DUE TO CERTAIN EVENTS.

The Administrator may increase or decrease the Participant's elections for those benefits that anticipate and incorporate automatically, within the permissible limits of Code Section 125, certain events occurring subsequent to this election. For example, but not by way of limitation, certain elections may be based upon a Participant's Compensation. To the extent such elections are made, and a Participant's Compensation changes during a Plan Year, the Administrator may make corresponding adjustments to reflect such changes.

# 8. ADMINISTRATION OF THE PLAN

## 8.1 APPOINTMENT OF ADMINISTRATOR.

The Administrator is the County's Human Resource Director with primary responsibility for human resource matters, or his or her delegate. The Administrator shall serve without additional compensation for these duties, unless otherwise determined by the Board.

## 8.2 ALLOCATION OF RESPONSIBILITY FOR ADMINISTRATION.

The Administrator may:

(a) Employ agents to carry out any Plan responsibilities.
(b) Consult with counsel, who may be of counsel to the County, or other experts and third parties.
(c) Designate one or more Employees to have responsibility for designing and implementing administrative procedures and/or performing administrative or other duties for the Plan.

Any delegation of responsibilities must be reflected in written form approved by the Administrator.

## 8.3 SCOPE OF ADMINISTRATOR.

The Administrator has all powers necessary or incident to the office as plan administrator to enable him or her to provide for the administration of the Plan.

## 8.4 SUBSTANTIATION OF REIMBURSEABLE EXPENSES.

Participants must incur Reimbursable Expenses by December 31st of the Plan Year for which applicable coverage was elected. Participants must submit all Reimbursable Expenses to the Administrator, or an applicable delegate, in accordance with the rules and procedures adopted by the Administrator by the first March 31st following the Plan Year for which applicable coverage was elected.

If a Participant terminates participation in the Plan with credit available in any account, such Participant must submit to the Administrator by the first March 31st following the applicable Plan Year claims for Reimbursable Expenses incurred during coverage periods on or prior to December 31 of the applicable Plan Year. Such claims must satisfy all substantiation requirements of the Administrator.

The Administrator may rely on any written or electronic statements by the Participant, his or her Spouse or any of his or her Dependents as to any matter under the Plan or its Appendices, including but not limited to declarations of fact or compliance with Code, Plan or other requirements, and will be under no duty to make investigations of the accuracy of such statements.

## 8.5 LIMIT ON COVERAGE.

Any coverage elected by a Participant under this Plan will cease if the Participant fails to make any required contributions toward such coverage.

## 8.6 NONDISCRIMINATORY EXERCISE OF AUTHORITY.

Whenever any discretionary action by the Administrator is required in the administration of the Plan, the Administrator will act in a nondiscriminatory manner to insure that persons similarly situated will receive substantially the same treatment.

## 8.7 PAYMENT OF ADMINISTRATIVE EXPENSES.

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any Administrator or third party administrative service provider, actuary, consultant, accountant, attorney,

specialist, or other person or organization that may be employed by the Administrator in connection with the Administration thereof, will be paid by Participants except to the extent an applicable Benefit Plan or Policy provides otherwise or the County pays such amounts.

## 8.8 INDEMNIFICATION OF ADMINISTRATOR.

The County agrees to indemnify and to defend to the fullest extent permitted by law any Employee or former Employee currently or formerly serving as an Administrator and any current or former Employee to whom duties have been or were delegated under this Article against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the County) occasioned by any act or omission to act in connection with the Plan if such act or omission is in good faith.

## 8.9 OTHER POWERS AND DUTIES OF THE ADMINISTRATOR.

The administration of the Plan will be under the supervision of the Administrator. It will be the principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination between them. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority in addition to all other powers provided by the Plan:

(a) To make and enforce such rules, procedures, deadlines and regulations as he or she deems necessary or proper for the efficient administration of the Plan, including the establishment of any procedures that may be required by applicable provisions of the law;

(b) To construe and interpret the Plan, its interpretation thereof to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any Employee to participate in the Plan and determine the amount of benefits and authorize payments;

(d) To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in the administration of the Plan;

(e) To delegate his or her responsibilities; under the Plan as provided in this Article 8;

(f) To comply with the requirements of reporting and disclosure under applicable law and to prepare and distribute communications to Employees as part of plan operations;

(g) To prescribe forms to facilitate the operation of the Plan;

(h) To secure government approvals for the Plan or otherwise respond to governmental inquiries on behalf of the Plan;

(i) To maintain records;

(j) To litigate, settle claims, and respond to and comply with court proceedings and orders on the Plan's behalf;

(k) To enter into contracts on the Plan's behalf;

(l) To exercise all other powers given to the Administrator under other Sections of the Plan; and

(m) To take all measures he or she deems reasonably necessary or desirable to properly administer the Plan.

Notwithstanding the foregoing, any claim, which arises from any underlying Benefit Plan or Policy, will not be subject to review under this Plan. In no way should the authority of this Plan's Administrator be construed to infringe on the authority of a separate Benefit Plan or Policy administrator.

# 9. INSURERS

## 9.1 PROVISIONS RELATING TO INSURERS.

If any provision of any insurance policy or contract conflicts with the provisions of this Plan, the provisions of the Plan will prevail to the extent necessary to maintain qualification under Code Section 125.

# 10. CLAIMS PROCEDURES

## 10.1 DENIED CLAIMS PROCEDURE UNDER THE PLAN.

Any Employee, beneficiary, or duly authorized representative may file a claim for a Plan benefit to which the claimant believes that he or she is entitled, but that has been previously denied by the Administrator. Such a claim must be in writing and delivered to the Administrator in person or by mail, postage paid, within the applicable period of time required by Labor Reg. section 2560.503. After receipt of such claim, the Administrator will send to the claimant, by mail, postage prepaid, within the applicable period of time required by Labor Reg. section 2560.503, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed that permitted by Labor Reg. section 2560.503. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial response period. The Administrator will have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with Section 10.2 the claim will be deemed denied and the claimant will be permitted to exercise claimant's right to review pursuant to Section 10.3 and 10.4.

## 10.2 REQUIREMENT FOR WRITTEN NOTICE OF CLAIM DENIAL.

The Administrator will provide to every claimant who is denied a claim for benefits a written notice, setting forth in a manner calculated to be understood by the claimant, the following information:

(a) Specific reason or reasons for denial;

(b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) Description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(d) Explanation of the Plan's claim review procedure.

## 10.3 RIGHT TO REQUEST HEARING ON BENEFIT DENIAL.

Within sixty (60) days after the receipt by the claimant of written notification of the denial (in whole or in part) of the claim, the claimant or claimant's duly authorized representative may make a written application to the Administrator, in person or by certified mail, postage prepaid, to be afforded a review of such denial, may review pertinent documents, and may submit issues and comments in writing.

## 10.4 DISPOSITION OF DISPUTED CLAIMS.

Upon receipt of a request for review, the Administrator will make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan or insurance policy provision on which the decision was based. The decision upon review will be made not later than sixty (60) days after the Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant will be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with this Section 10.4, the claim will be deemed denied, and the claimant will be permitted to exercise claimant's right to legal remedy pursuant to Section 10.5.

## 10.5 LEGAL ACTIONS.

A claimant must exhaust the claims procedures described in this Article 10 before he may bring a legal action in court against any of the Plan parties. No legal action may be brought on a claim for benefits under the Plan after 180 days following the Administrator's final decision (or deemed decision if no notice of the decision is furnished) on the benefit claim.

10.6 Underlying Benefit Plan or Policy.

Notwithstanding the foregoing, any claim, which arises from any underlying Benefit Plan or Policy, will not be subject to review under this Plan. Claims and appeals arising from any underlying Benefit Plan or Policy shall be subject to review under the claims and appeals rules and procedures of such underlying Benefit Plan or Policy.

# 11. PLAN AMENDENT AND TERMINATION

## 11.1 FUTURE OF THE PLAN.

While the County expects that this Plan will continue into the future, the continuation of the Plan is subject to the County's right to amend or terminate the Plan, as provided in Sections 11.2 and 11.3 below.

## 11.2 COUNTY'S RIGHT TO AMEND.

The County reserves the right to:

(a) Amend the Plan at any time and from time to time, and retroactively, if deemed necessary or appropriate for any reason whatsoever; and

(b) Modify or amend, in whole, or in part any or all of the provisions of the Plan.

The Board may make any such decision to amend the Plan. In addition, the County's Assistant County Administrative Officer with primary responsibility for human resource matters, acting in his or her capacity as officer of the County as plan sponsor and not as administrator, may make any amendment:

(a) To comply with applicable laws, rules, or regulations;

(b) To conform with an applicable memorandum of understanding or other collective bargaining agreement;

(c) To make technical corrections if such corrections do not otherwise have a substantial impact on the cost or terms of benefits provided by the County;

(d) To the extent delegated or requested in writing by the Board.

## 11.3 COUNTY'S RIGHT TO TERMINATE.

The County reserves the right to discontinue or terminate the Plan without prejudice at any time without prior notice. Such decision to terminate the Plan shall be made in writing by the Board.

## 11.4 DETERMINATION OF EFFECTIVE DATE OF AMENDMENT OR TERMINATION.

Any such amendment, discontinuance or termination shall be effective as of such date as specified in such amendment or discontinuance or termination writing.

## 12. MISCELLANEOUS PROVISIONS

### 12.1 LIMITATION OF RIGHTS.

Neither the establishment of the Plan nor any amendment thereof nor the payment of any benefits will be construed as giving to any Participant or other person any legal or equitable right against the County or Administrator except as provided herein.

### 12.2 NOT AN EMPLOYMENT CONTRACT.

Neither this Plan nor any action taken with respect to it confers upon any person the right of employment or continued employment with the County.

### 12.3 GOVERNING LAW.

This Plan will be construed, administered, and enforced according to applicable Federal law and, unless preempted by Federal law, the laws of the State of California.

### 12.4 POSTMORTEM PAYMENTS.

Any Benefit payable under the Plan after the death of a Participant will be paid to the surviving Spouse (if any), same gender spouse (if any), domestic partner registered for state law purposes (if any), or designated beneficiary (if any), otherwise, to the Participant's estate. If there is doubt as to the right of any beneficiary to receive any amount, the Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon, or it may pay such amount into any court of appropriate jurisdiction, in either of which events neither the Administrator, nor the County, shall be under any further liability to any person.

### 12.5 NON-ALIENTATION OF BENEFITS.

No benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so will be void.

### 12.6 MENTAL OR PHYSICAL INCOMPETENCY.

If the Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, the Administrator may cause all payments thereafter becoming due to such person to be made to any other person for the Participant's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section will completely discharge the Administrator and County from further liability hereunder.

### 12.7 INABILITY TO LOCATE PAYEE.

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because the identity, or whereabouts of such Participant or other person cannot be ascertained after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of each Participant or other person as shown on the records of the County), such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited seven (7) years after the date any such payment first became due.

### 12.8 REQUIREMENT FOR PROPER FORMS.

All communications in connection with the Plan made by a Participant will become effective only when timely and duly executed on any forms as may be required and furnished by, and filed with, the Administrator.

12.9 SOURCE OF PAYMENTS.

The County and any insurance company contracts purchased or held by the County will be the sole sources of benefits under the Plan. No Employee or beneficiary will have any right to, or interest in, any assets of the County upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

12.10 MULTIPLE FUNCTIONS.

Any person or group of persons may serve in more than one capacity with respect to the Plan.

12.11 TAX EFFECTS.

Neither the County nor the Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Participant hereunder will be treated as excludable from gross income for State or Federal income tax purposes.

12.12 GENDER, NUMBER AND HEADINGS.

Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context. The Section headings contained herein are for convenience of reference only, and are not to be construed as defining or limiting the matter contained thereunder.

12.13 INCORPRATION BY REFERENCE.

The actual terms and conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. Such separate, written document may be reflected in a separate plan document, insurance policy or contract, summary plan description, memoranda of understanding or union side letters, and/or enrollment and other materials, as applicable.

12.14 SEVERABILITY.

Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

12.15 CLAIMS AND ISSUES.

From time to time, claims or issues may arise that involve the Plan, including, among others, claims and issues raised by Employees, Participants, Spouses or Dependents, those addressed by the Internal Revenue Service or other government agencies or courts. The resolution, settlement, or adjudication of these claims or issues may result in an action that is not expressly permitted under some other section of the Plan document. Such a procedure, agreement, or order will be respected to the extent that, as determined in the sole discretion of the Administrator, it does not result in disqualification of the Plan or violate (or cause the Plan to violate) any applicable statute, government regulation, or ruling.

12.16 HIPAA PRIVACY RULES.

The County shall have access to Employees' health information under this Plan only as part of its administration of enrollment and disenrollment functions. The County is not a HIPAA "covered entity" and the health information is not "protected health information" in this context but the County shall comply with any other applicable privacy laws and rules.

APPENDIX A:
DEPENDENT CARE ASSISTANCE PLAN

1. PURPOSE

This Dependent Care Assistance Plan (DCAP) has been established by the County as a dependent care assistance program under Section 129 of the Internal Revenue Code for the benefit of Eligible Employees who are eligible for the County Of Monterey Section 125 Flexible Benefits Plan (the "Plan") and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a dependent care expense reimbursement spending account established pursuant to this DCAP. A Participant may utilize his or her dependent care expense reimbursement spending account to reimburse eligible expenses for the custodial care of a child, parent or other eligible dependent, when such custodial care is needed to enable the Participant or his or her Spouse to remain employed. This DCAP is intended to provide reimbursement of dependent care expenses that are excludable from the Participant's gross income under Section 129 of the Code. This DCAP is a component of, and incorporated by reference into, the Plan.

1.1 DEFINITIONS.

Unless otherwise specified, terms that are capitalized in this Appendix A have the same meaning as the defined terms in the Plan. The definitions of terms defined in this Appendix A, but not defined in Section 2 of the Plan shall be applicable only with respect to this Appendix A. To the extent a term is defined both in the Plan and in this Appendix A, the term as defined in the Plan shall govern the interpretation of the Plan and the term as defined in this Appendix A shall govern the interpretation of this Appendix A.

1.2 DEPENDENT CARE ASSISTANCE ACCOUNT.

The account under the Dependent Care Assistance Plan described in Section 5 hereof, which is considered a sub-account or Individual Coverage Account under the Plan.

1.3 DEPENDENT CARE EXPENSES.

Reasonable expenses incurred by the Participant for the provision of custodial care for the Participant's Eligible Dependent, which care is performed to enable the Participant or his Spouse to remain gainfully employed, subject to any limitations herein or in the Plan. Tuition (or other educational expenses) for kindergarten and above are not eligible Dependent Care Expenses. The Administrator (or its designated claim administration representative) shall determine in its sole discretion whether any expense is reasonable. To be eligible for reimbursement as a Dependent Care Expense, an expense must be related to:

(a) the cost of sending a child or other Eligible Dependent of the Participant to an Eligible Day Care Center,

(b) the cost of custodial care performed in the home of the Participant for an Eligible Dependent; or

(c) the cost of custodial care performed outside the home of the Participant for

(1) the care of an Eligible Dependent of the Participant under the age of 13; or

(2) the care of any other Eligible Dependent who spends at least eight hours a day in the Participant's home.

Notwithstanding the foregoing, an expense shall be an eligible Dependent Care Expense only if it is payable to a person who is not

(a) a dependent for whom either the Participant or the Participant's Spouse may claim a deduction under Code Section 151(c),

(b) the Participant's Spouse; or

(c) a child of the Participant (within the meaning of Code section 152(f)(1)) under the age of 19 as of the close of the Plan Year in which the custodial care services with respect to the Eligible Dependent are rendered.

1.4 EDUCATIONAL INSTITUTION.

Any educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

1.5 ELIGIBLE DAY CARE CENTER.

A day care center which provides full-or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the calendar year, and which

(a) complies with all applicable laws and regulations of the state and town, city or village in which it is located; and

(b) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for profit)

1.6 ELIGIBLE DEPENDENT.

(a) a dependent of the Participant who is a "qualifying child" under Code Section 152(a)(1) and under the age of 13; provided that, in the case of divorced parents, Eligible Dependent shall be defined as in code Section 21(e)(5) (i.e. dependent of the parent with custody); or

(b) a dependent as defined in Code Section 152 (determined for this purpose without regard to subsections (b)(1), (b)(2) and (d)(1)(B) of Section 152) or Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal address as the employee for more than half the taxable year.

1.7 PARTICIPANT.

An individual Employee who participates in this DCAP in accordance with Section 3.

1.8 SPOUSE.

A Spouse as defined in Article 2 of the Plan, but excluding for purposes of this Appendix A an individual legally separated from a Participant under a decree of legal separation and a spouse living apart from the Participant who is considered not to be married to him or her under the special rules at Code Section 21(e)(4).

## 2. PARTICIPATION

### 2.1 COMMENCEMENT OF PARTICIPATION.

Each Employee, regardless of scheduled hours or status as full or part-time, shall be eligible to participate in this DCAP as of the date he becomes eligible to elect supplemental benefits under the Plan. Except as provided in the next sentence, such an individual will become a Participant in the DCAP on the first day of the first Plan Year for which he or she elects under the Plan to contribute, by means of making an election on his or her Enrollment Flex Form, to a Dependent Care Assistance Account under this DCAP for the reimbursement of Dependent Care Expenses. An individual who is permitted, under the terms of the Plan, to make an election on his or her Enrollment Flex Form with respect to this DCAP which is effective other than at the beginning of a Plan Year shall become a Participant no later than the beginning of the month subsequent to timely and proper completion and submission of enrollment forms.

### 2.2 CESSATION OF PARTICIPATION.

A Participant will cease to be a Participant in the DCAP as of the earliest of (a) the date on which this DCAP or the Plan terminates; (b) the end of the Plan Year, unless the Participant makes another election to receive benefits under this DCAP for the next Plan Year; (c) the date on which the Participant is no longer eligible to participate in the Plan; or (d) the date on which his or her election to receive benefits under this DCAP otherwise expires or is terminated under the Plan.

## 3. ELECTIONS

### 3.1 ELECTION OF BENEFITS.

A Participant may elect to contribute to a Dependent Care Assistance Account under this DCAP and to receive reimbursement of his Dependent Care Expenses by filing an election on his or her Enrollment Flex Form in accordance with the procedures established by the Administrator under the Plan.

### 3.2 PLAN LIMITS.

The Administrator may establish procedures to limit the amount of a Participant's contributions to this DCAP in order to prevent the amount of such contributions to exceed the maximum annual amount which the Participant may receive in reimbursement of Dependent Care Expenses as described in Section 3.4.

### 3.3 OTHER ADMINISTRATIVE DOCUMENTATION

The Administrator may require the Participant, on an annual basis, to file a statement or otherwise acknowledge that he intends to file Form 2441 with the Internal Revenue Service. In addition, if the Participant elects to contribute more than $2,500 to his Dependent Care Assistance Account, the Administrator may require the Participant to verify that he is either unmarried or that, if married, he does not intend to file a separate Federal tax return.

### 3.4 MAXIMUM CONTRIBUTION AMOUNT.

The maximum amount which the Participant may receive in the form of dependent care assistance under this DCAP with respect to Dependent Care Expenses incurred in any calendar year, shall be the least of:

(a) the Participant's earned income for the calendar year,

(b) the actual or deemed earned income of the Participant's Spouse for the calendar year, if the Participant is married,

(c) $5,000 (including both Participant contribution and any County match), if the Participant is unmarried or married and will file a joint Federal income tax for the calendar year, or

(d) $2,500 (including both Participant contribution and County match), if the Participant is married and will not file a joint Federal income tax return for the calendar year.

For purposes of the foregoing, "earned income" means all income derived from salaries, wages, tips, self-employment, overtime, bonuses and other taxable employee compensation (such as disability or wage continuation benefits) but does not include any amounts (i) received under the DCAP or any other dependent care assistance DCAP under Section 129 of the Code, (ii) as a pension or annuity, or (iii) other amounts excluded under Code section 129. In the case of a Spouse (i) who is a full-time Student at an Educational Institution or (ii) who has the same principal residence as the Participant for more than one-half of the Plan Year and is physically or mentally incapable of caring for himself or herself, such Spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Eligible Dependent and $500 per month if the Participant has two or more Eligible Dependents. In the case of two Participants who are married to each other and who file a joint Federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the year under this DCAP by the Participant's Spouse.

Notwithstanding the foregoing, a Participant shall not be permitted to contribute to this DCAP a periodic amount which, when projected for the remainder of the Plan Year, would exceed the Participant's earned income for the calendar year, less the projected contribution amount elected by the Participant for the Plan Year with respect to this DCAP.

### 3.5 DURATION OF ELECTION.

Once effective, any election (and related Enrollment Flex Form, including the Salary Reduction Agreement) with respect to this DCAP shall remain in effect until the end of the Plan Year for which it was made, except as provided in the Plan.

Should the contribution amount be increased, the amount of the increase will be prorated throughout the remaining calendar year. Should the contribution amount be decreased, the amount contributed per paycheck will be recalculated. In no circumstances may the amount contributed be less than what has previously been reimbursed. If a Participant separates from service with the County (including by reason of layoff) during a period in which he is covered under the DCAP, begins an unpaid leave of absence or otherwise ceases to be a Participant, then contributions to his Dependent Care Assistance Account shall cease with his final paycheck. Such a Participant shall be entitled to reimbursement of claims with respect to Dependent Care Expenses incurred while actively participating in the DCAP prior to termination, layoff, leave or other cessation of participation (but not in excess of the amounts credited to his Dependent Care Assistance Account).

3.6 MINIMUM CONTRIBUTION AMOUNT.

There is no minimum amount which the Participant may receive in the form of dependent care assistance under this DCAP with respect to Dependent Care Expenses incurred in any calendar year.

## 4. DEPENDENT CARE ASSISTANCE ACCOUNTS

### 4.1 ESTABLISHMENT OF ACCOUNTS.

The County will establish and maintain on its books a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Plan Year, as described in Sections 6 and 7 of the Plan.

### 4.2 CREDITING OF ACCOUNTS.

There shall be credited to a Participant's Dependent Care Assistance Account for each Plan Year, as of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any to be made in such Compensation in accordance with the Participant's election under the Plan. All amounts credited to each such Dependent Care Assistance Account shall be the property of the County until paid out pursuant to Section 6 of the Plan.

### 4.3 DEBITING OF ACCOUNTS.

A Participant's Dependent Care Assistance Account for each Plan Year shall be debited from time to time in the amount of any payment under Section 6 of the Plan or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year. Amounts debited to each such Dependent Care Assistance Account shall be treated as payments of the earliest amount credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

### 4.4 FORFEITURE OF DEPENDENT CARE ASSISTANCE ACCOUNTS.

The amount credited to a Participant's Dependent Care Assistance Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year while a Participant prior to the benefit cessation date. Such amounts are available only if the Participant (or his estate) applies for reimbursement on or before the first March 31st following the close of the Plan Year.

If any balance remains in the Participant's Dependent Care Assistance Account for a Plan Year after all timely reimbursements permitted hereunder, such balance shall not be carried over to reimburse the Participant for any Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the County, to the extent permitted by law, and the Participant shall forfeit all rights with respect to such balance.

# 5. PAYMENT OF DEPENDENT CARE ASSISTANCE

## 5.1 CLAIMS FOR REIMBURSEMENT.

A Participant who has elected to receive dependent care assistance for a Plan Year may apply to the Administrator or its designated claims administration representative, for reimbursement of Dependent Care Expenses. The application shall be in such form as the Administrator (or its designated claims administration representative) may prescribe. The application shall be accompanied by a written statement or invoice from an independent third party stating or indicating that the expense has been incurred and the amount of the expense. The Administrator, or its designated claims administration representative, may also require as part of the application such other information or documentary evidence (e.g. , bills, receipts, canceled checks) as it may deem necessary or desirable to ascertain the eligibility of a Participant‘s claim for reimbursement.

## 5.2 REIMBURSEMENT OR PAYMENT OF EXPENSES.

The Participant shall be reimbursed from the Participant’s Dependent Care Assistance Account, at such time and in such manner as the Administrator or its claim administration representative may prescribe, but no less frequently than monthly, for Dependent Care Expenses incurred during the Plan Year by a Participant, for which the Participant makes written application and submits documentation in accordance with Section 5.1 of this Appendix. The Administrator (or its claims administration representative) may at its option or in accordance with the Participant’s written direction, pay any such Dependent Care Expenses directly to the provider of services with respect to such expenses in lieu of reimbursing the Participant. No reimbursement or payment under this Section 5.2 of expenses shall at anytime exceed the balance of the Participant’s Dependent Care Assistance Account for the Plan Year at the time of the reimbursement or payment, nor shall any reimbursement or payment be made if the Participant’s claim is for an amount less than the minimum reimbursable amount as may be established by the Administrator. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the minimum reimbursable amount described in the preceding sentence shall be carried over and reimbursed or paid only if and when the Participant’s unreimbursed claims equal or exceed such minimum and the balance in the Participant’s Dependent Care Assistance Account permits such reimbursement or payment. Notwithstanding the preceding sentence, claims for Dependent Care Expenses incurred during a Plan Year that are timely submitted for reimbursement under the Plan rules and as may be required by the Administrator, shall be paid following the close of the Plan Year regardless of whether they equal or exceed the minimum reimbursable amount, provided the balance in the Participant’s Dependent Care assistance Account permits such reimbursement or payment.

## 5.3 REPORT(S) TO PARTICIPANTS.

The Administrator shall furnish or cause to be furnished to each Participant (or former Participant) who has received dependent care assistance under this DCAP during the Plan Year a written statement showing the amount of such assistance paid during such year with respect to the Participant (or former Participant). Such report must be furnished at least annually, but may be provided more frequently.

## 5.4 LIMITATION ON REIMBURSEMENTS OR PAYMENTS WITH RESPECT TO CERTAIN PARTICIPANTS.

Notwithstanding any other provisions of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of applicable Code Sections) to the extent the Administrator deems such limitation to be necessary to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture.

# 6. ADMINISTRATION

## 6.1 ADMINISTRATOR.

The administration of the DCAP shall be under the supervision of the Administrator, the responsibilities of which are set forth in Section 8 of the Plan. The powers, rights and protections ascribed or provided to the Administrator under the Plan shall likewise apply with respect to their duties under this DCAP, and are incorporated herein by reference.

## 6.2 RECORDS.

The Administrator shall keep or cause to be kept appropriate books and records with respect to the operations and administration of this DCAP.

## 6.3 RELIANCE OF DETERMINATIONS, ETC.

In administering the DCAP, the Administrator and/or its delegate will be entitled, to the extent permitted by law, to rely conclusively on all certificates, determinations, opinions and reports which are furnished by any accountant, counsel, claims administrator or other expert who is employed or engaged by the Administrator.

## 6.4 CLAIMS PROCEDURE.

The process by which a claim for benefits shall be handled by the Administrator and the process by which a Participant may appeal the denial of a claim for benefits are set forth in the Plan and incorporated herein by reference.

## 7. AMENDMENT AND TERMINATION

The County reserves the right at any time or times to amend or terminate the provisions of the DCAP, to any extent and in any manner that it may deem advisable, as specified in the Plan.

## 8. MISCELLANEOUS

### 8.1 FUNDING STATUS OF DCAP.

Except as may otherwise be required by law or under the terms of the Plan

(a) Any amount by which a Participant's taxable compensation is reduced by reason of election made under this DCAP will remain part of the general assets of the County,

(b) The benefits provided hereunder will be paid solely from the general assets of the County,

(c) Nothing herein will be construed to require the County or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and

(d) No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the County from which any payment under the DCAP may be made.

### 8.2 ASSIGNMENT.

The Participant may, if permitted by the Administrator, authorize the DCAP to pay a Participant's reimbursement of Dependent Care Expenses directly to the provider of services with respect to such expenses. Except as provided in the foregoing sentence, a Participant may not assign, alienate, anticipate or commute any payment with respect to any reimbursements of Dependent Care Expenses which a Participant is entitled to receive from the DCAP and, further, except as may be prescribed by law, no benefits shall be subject to any attachments or garnishments of or for a Participant's debts or contracts, except for recovery of overpayments made on the Participant's behalf by the DCAP.

### 8.3 NO GUARANTEE OF TAX CONSEQUENCE.

Neither the Administrator nor the County makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this DCAP will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the DCAP is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Administrator if the Participant has reason to believe that any such payment is not so excludable.

### 8.4 INDEMNIFICATION OF COUNTY BY PARTICPANTS.

If any Participant receives one or more payments or reimbursements under this DCAP that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the County and Administrator for any liability it or they may incur for failure to withhold Federal or State income tax or Social Security tax from such payments or reimbursements.

APPENDIX B:
FLEX CREDIT AND FLEX DOLLAR RATE SHEET

APPENDIX C:

HEALTH FLEXIBLE SPENDING ACCOUNT

## ARTICLE IX
## PARTICIPANT ELECTIONS

### 9.1 INITIAL ELECTIONS

An Employee, who is classified as a permanent employee, regularly scheduled to work at least 20 hours or more per week, are paid on a United States payroll and who meets the eligibility requirements, during open enrollment for the upcoming Plan Year, may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation. An individual who is permitted, under the terms of the Plan, to make an election on his or her Enrollment Flex Form with respect to this Health FSA which is effective other than at the beginning of a Plan Year shall become a Participant no later than the beginning of the month subsequent to timely and proper completion and submission of enrollment forms.

### 9.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 9.4.

### 9.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 4 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

### 9.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(f) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(g) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

## ARTICLE X
## HEALTH FLEXIBLE SPENDING ACCOUNT

### 10.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

### 10.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their ***Employee Paid Pre-Tax Dollars*** may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed. The ***Employee Paid Pre-Tax Dollars*** is defined as the pre-tax election that an employee makes to fund their Health Flexible Spending Account for the Plan Year.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 107(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article 2 are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

## 10.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to ***Section 10.7*** hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to ***Section 11.2.***

## 10.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2500. Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary reductions that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,500, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2).

(b) For any short Plan Year, the maximum amount that may be allocated to the Health Flexible Spending Account is $1,250.

(c) **Cost of Living Adjustment.** In no event shall the amount of salary redirections on the Health Flexible Spending Account exceed $2,500 as adjusted by law. Such amount shall be adjusted for increases in the cost-of-living in accordance with Code Section 125(i)(2). The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(d) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the $2,500 limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to $2,500 (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to $2,500 (as adjusted) under each Employer's Health Flexible Spending Account.

(e) **Carryover.** A Participant in the Health Flexible Spending Account may roll over up to $500 of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of $500 will be forfeited. The Plan will treat claims as being paid first from the current year amounts, then from the carryover amounts.

## 10.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

## 10.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute the eligibility to enroll under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

## 10.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.8, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of ***Employee Paid Pre-Tax Dollars*** which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan

Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

## 10.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and will be reissued prior to card expiration or if the card is lost/stolen, for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 10.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2007-79. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

## ARTICLE XI
## BENEFITS AND RIGHTS

### 11.1 CLAIM FOR BENEFITS

(a) **Health Flexible Spending Account claims.** Any claim for Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(b) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(c) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(d) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 10.3, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

### 11.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

## ARTICLE XII
## ADMINISTRATION

### 12.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

### 12.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

### 12.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

### 12.4 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## ARTICLE XIII
## AMENDMENT OR TERMINATION OF PLAN

### 13.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

### 13.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made.

No further additions shall be made to the Health Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

## ARTICLE XIV
## MISCELLANEOUS

### 14.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 10.11.

## 14.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

## 14.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

## 14.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

## 14.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

## 14.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

## 14.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer 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, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

## 14.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

## 14.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

## 14.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

## 14.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

## 14.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

## 14.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

## 14.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

## 14.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

## 14.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

## 14.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage,

provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

**14.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 14.17.

**14.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

**14.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

**14.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

**14.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

**IN WITNESS WHEREOF**, this Amended Plan document is hereby executed this ________ day

of ______________ , 19 ____.

**THE COUNTY OF MONTEREY**

By______________________________________
Employer