THE COUNTY OF MONTEREY
SECTION 125 FLEXIBLE BENEFIT PLAN

AMENDED AND RESTATED
PLAN DOCUMENT

As Adopted By
The County of Monterey
Effective January 1, 2013

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, and the County of Monterey Alternative Benefit Option (ABO) Account Section 125 Flexible Benefit Plan, originally effective January 1, 2002.

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.

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, and Dependent Care Assistance 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 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 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.

2.15 ELIGIBLE EMPLOYEE.

An Employee who has satisfied the Eligibility Requirements.

2.16 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) Not be a member of a union or other bargaining unit, unless the bargaining agreement provides for coverage under this Plan; and

(d) 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.

2.17 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.

2.18 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.

2.19 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.

2.20 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.

2.21 INSURER.

Any insurance company that has issued a Policy.

2.22 PARTICIPANT.

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

2.23 PARTICIPANT ACCOUNT.

The account described in Section 6.1 herein.

2.24 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.

2.25 PLAN YEAR.

The Plan Year is the calendar year, starting January 1 and ending December 31.

2.26 POLICY.

Any insurance policy pursuant to which Qualified Benefits are provided.

2.27 QUALIFIED BENEFITS.

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

2.28 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.

2.29 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.

2.30 SPOUSE.

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

2.31 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 REINSTATMENT 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.

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

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 ELECTION 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 AMMENDENT 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

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

of _____________ , 19 ____.

THE COUNTY OF MONTEREY

By____________________________________

Employer