CHATHAM COUNTY –SAVANNAH METROPOLITAN PLANNING COMMISSION
FLEXIBLE AND DEPENDENT CARE BENEFITS PLAN

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CHATHAM COUNTY - SAVANNAH METROPOLITAN PLANNING COMMISSION
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INTRODUCTION

The Chatham County-Savannah Metropolitan Planning Commission ("Employer") has amended this "Plan" effective January *2016* to recognize the contribution made to the Employer by its Employees. Its purpose is to provide reimbursement of certain eligible Healthcare and Dependent Care Expenses for those Employees who shall qualify hereunder and their dependents as specified in the Internal Revenue Codes Section 152.

This Plan is to allow Employees to choose a health Flexible Spending Account (FSA) benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally adopted on February 1, 1991. The Plan shall be known as the Chatham County – Savannah Metropolitan Planning Commission Flexible and Dependent Care Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 2001, as amended, and that the benefits which an Employee elects to receive under the Plan be includable or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 2001, as amended.

The Employer reserves the rights to alter, amend, modify, or terminate the Plan, in whole or in part, at any time for any reason in a manner consistent with the provisions listed in Article X.

ARTICLE I

DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated hereto or amendment hereto, have the meanings as set forth below. Words in the masculine gender include the feminine gender, and vice versa. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

1.1 "*Annual Enrollment Period*" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscrimination basis for all Employees and Participants. However, an Employee's Initial Election Period shall be determined pursuant to Section 5.1.

1.2 "Administrator" means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.3 *"Benefit"* means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "Carryover " means the Plan may allow up to $500 of unused amounts remaining at the end of the plan year to be paid or reimbursed for qualified medical expenses incurred in the following plan year. The Participant will forfeit any unused amounts in excess of the carryover amount. The carryover does not affect the maximum amount of Salary Reductions contributions that Participants are permitted to make Section 8.1(d)

1.5 "Cafeteria Plan Benefit Dollars" means the amount available to Participants, pursuant to Article I III, to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit dollar.

1.6 "Code" means the Internal Revenue Code of 2000, as amended or replaced from time to time.

1.7 "Dependent" means any individual who qualifies as a dependent under an Insurance Contract under Code Section 152 (as modified by Code Section *105(b)).*

1.8 "Effective Date" means date plan was adopted February 1, 1991.

1.9 "Eligible Employee" means any Employee who has satisfied the provisions of Section 2.1.

1.10 "Employee" means any person who is employed by the Employer, but excludes any person who is employed as an independent contractor.

1.11 "Employer" means the Chatham County-Savannah Metropolitan Planning Commission and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

1.12 "Enrollment Form" means a form prescribed by the Plan Administrator for the purposes of enrolling Participants under the Plan, or for changing or waiving such coverage in the Plan

1.13 "Grace Period" means the plan may allow a grace period extension that immediately follows the end of the plan year, two month and 15 days (March 15th). During this time period, Dependent Care Expenses incurred can be used for reimbursement against funds remaining from the prior plan year. Any prior plan year funds not used are forfeited after April 30th Section 8.1(d).

1.14 "Insurance Contract" means any contract issued by an Insurer underwriting a Benefit.

1.15 "Insurance Premium Expense Account Plan" means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.16 "Insurer" means any insurance company that underwrites a Benefit under this Plan.

1.17 "Key Employee" means an Employee described in Code Section 416(i) (1) and the Treasury Regulations thereunder.

1.18 "Participant" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 "Plan" means this instrument, including all amendments thereto.

1.20 "Plan Year" mean the 12-month period beginning January 1st and ending on December 31st. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 "Premium Expenses" or "Premiums" mean the Participant's cost for the insured Benefits described in Section 4.1.

1.22 "Premium Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 "Spouse" means the legally married husband or wife of a Participant, unless legally separated by court decree.

1.26 *"Domestic Partner" means adults who choose to live in the same manner as a married couple but who are not married.*

ARTICLE II

PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

Any new hired or rehired active employee regularly scheduled to work at least 20 hours per week shall be eligible to participate in the Plan as of the day 31st day after beginning of employment.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of the pay period coinciding with or next following the date on which he met the eligibility requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable *Enrollment Period, change, modify or waive the rate of contribution by submitting a completed enrollment form furnished by the Plan Administrator to the Employee.* The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof

An Eligible Employee shall also be required to execute a Salary Reduction Agreement during the Enrollment Period for the Plan Year during which they wishes to participate in this Plan. Any such Salary Reduction Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) His termination of employment, subject to the provisions of Section 2.6;

(b) The end of the Plan Year during which he became a limited Participant because of a change in employment status pursuant to Section 2.5;

(c) His death, subject to the provisions of Section 2.7; or

(d) The termination of this Plan, subject to the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs.

As a limited Participant, no further Salary Reduction may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

For the purpose of Dependent Care Expenses: Any balances in the limited Participant's Dependant Care Expense Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care Expenses incurred during the Plan Year.

2.6 TERMINATION OF EMPLOYMENT

If a Participant terminates employment with the Employer for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

(a) With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Reduction contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for the remainder of the Plan Year in which such termination occurs, based on the level of his Dependent Care Assistance Account as of their date of termination.

(c) With regard to the Heath Care Reimbursement Plan, the Participant's participation in the Plan shall cease and no further Salary Reduction contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding their date of termination.

(d) In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Reductions are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Reduction previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(e) This Section shall be applied and administered consistent with such further rights a Participant and their Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.7 DEATH

If a Participant dies, their participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 *SALARY REDUCTION*

Benefits under the Plan shall be financed by *Salary Reductions* sufficient to support Benefits or Premium Expenses a Participant has elected pursuant to Article IV. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefits. The amount of such Salary Reduction shall be specified in the *Salary Reduction* Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the *Salary Reduction* Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any *Salary Reduction* shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Reduction Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in family status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. *Salary Reduction* amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual *Salary Reduction* Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Reduction to provide the Benefits elected by the affected Participants. Any contributions made or withheld for the Health Care Reimbursement Account or Dependent Care Assistance Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Account shall likewise be credited to such account for the purpose of paying dependent Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Reductions be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Reductions are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Reductions are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Reductions pursuant to Section 2.6.

ARTICLE IV

BENEFITS

The benefits available under this Plan for a Plan Year shall take the form of pre-tax reimbursements for Healthcare Expenses and Dependent Care Expenses incurred during the Plan Year and the ensuring Carryover Period. A Participant shall be entitled to reimbursement under this Plan only for Healthcare Expenses and Dependent Care Expenses incurred after their participation has commenced and before their participation has ceased.

4.1 BENEFIT OPTIONS

Each Participant may elect to have the amount of his Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

(1) Health Care Reimbursement Plan

(2) Dependent Care Assistance Program

(3) Premium Insurance Account
(1) Health Insurance Benefit
(2) Dental Insurance Benefit

4.2 HEALTH CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Health Care Reimbursement Plan option, in which case Article VI shall apply.

(a) Amount of Reimbursement shall be given during the Plan Year and the ensuring Carryover Period, a Participant shall be entitled to reimbursement under this Plan in an amount that does not exceed the anticipated amount to be allocated on his behalf under the Plan for payment of Healthcare Expenses under the Plan for the Plan Year (less any previously reimbursed Healthcare Expenses), regardless of the actual amount then standing to the Participant's credit under the Plan for payment of Healthcare Expenses. Each payment hereunder shall be charge against the amount available to pay Healthcare Expenses under the Plan.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

Each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

(a) A participant shall be entitled to reimbursement of Dependent Care Expenses under this Plan in the amount that does not exceed the actual amount then standing to the Participant's credit under the Plan for payment of Dependent Care Expenses. Each Payment hereunder shall be charged against the amount available to pay Dependent Care Expenses under the Plan.

4.4 PREMIUM HEALTH INSURANCE ACCOUNT BENEFIT

(a) Each Participant may elect to be covered under a Health and Hospitalization Insurance Contract for the Participant, his or her spouse, and his or her dependents. The premium expenses include the Participant's share of the health insurance premiums.

(b) The City may select suitable Health and Hospitalization Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such

Health and Hospitalization Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFITS

(a) Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract. Participant may also elect either *Basic or High Option* coverage.

(b) The Employer may select suitable Dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) The rights and conditions with respect to the benefits payable from such Dental Insurance Contract shall be determined therefrom, and such Dental Insurance Contract shall be incorporated herein by reference.

4.6 CASH BENEFIT

If a Participant does not elect any Salary Reductions, such Participant shall be deemed to have chosen the Cash Benefit as his sole Benefit option.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includable in gross income.

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable 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 election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among non-insured Benefits, and once all non-insured Benefits are expended proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V

PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so before his effective date of participation pursuant to Section 2.2. However, if such Employee does not complete an enrollment form to participate and deliver it to the Plan Administrator before such date, his Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's effective date of participation pursuant to Section 2.2 or the date of the receipt of the enrollment form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the enrollment is made.

5.2 SUBSEQUENT ANNUAL ENROLLMENT

During the Enrollment Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an enrollment of benefits form to be provided by the Administrator, which Benefit options he wishes to select and purchase with his 125 Cafeteria Plan Benefit Dollars. Any such enrollment shall be effective for Healthcare and Dependent Care reimbursement expenses incurred during the Plan Year which follows the end of the Enrollment Period. With regard to subsequent annual enrollments, the following options apply:

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

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Enrollment 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

Enrollment Period will have to wait until the next Enrollment Period before again electing to participate in the Plan.

5.3 FAILURE TO ENROLL

Any Participant failing to complete an enrollment of benefits form pursuant to Section 5.2 by the end of the applicable *Enrollment Period* shall be deemed to have waived the Healthcare and Dependent Care Benefits option enrollment that were in effect for the current Plan Year. The Participant shall also be deemed to have waived the Salary Reduction Agreement for the current year.

5.4 CHANGE OF ELECTIONS

(a) 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.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment, legal separation from a spouse or (*change in status relating to a domestic partner),* the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, of the participant, spouse or dependent gains eligibility for coverage, then a Participant's election under the plan to cease or decrease coverage for that individual becomes applicable or is increased under the family member plan.

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 enrollment 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) *Change in Domestic Partnership: Dissolution of partnership or change in domestic partner employment status.*

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

(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

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21 (b) shall also qualify as a change in status.

(b) 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 the Code Section 980(f). Such change shall take place on a prospective basis.

(c) Notwithstanding subsection (a), in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) 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) Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled on 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) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Reductions of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

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.

A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse, *domestic partner*, 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 health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

A Participant may make a prospective election change that is on account of and corresponds with a change made under a plan of a spouse's, former spouse's, *domestic partners*, or dependent's employer if (1) the cafeteria plan or other benefits plan of the spouse's, former spouse's, *domestic partner* or dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a spouse's, former spouse’s, *domestic partners*, or dependent’s employer.

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

A participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection.

ARTICLE VI

HEALTH CARE REIMBURSEMENT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Care Reimbursement Plan 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 Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Account. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

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

(a) “Health Care Reimbursement Account” means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.

(b) “Health Care Reimbursement Plan” means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or *their* Dependents.

(c) “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 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.

(d) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 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. However, 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 their spouse, *domestic partner*, or Dependent. Furthermore, a participant may not be reimbursed for "qualified long-term care services " as defined in Code Section 7702B(c).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 FORFEITURES

The amount in the Health Care Reimbursement Fund as of the end of any *Carryover Period* (and after the processing of all claims for such Plan Year pursuant to Section 6.7 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 8.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, no more than the federally maximum amount may be allocated to the Health Care Reimbursement Fund by a Participant, in or on account of any Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, 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 Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Sections 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 Sections 105 who has elected the second highest contribution to the Health Care Reimbursement Fund 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.

6.6 COORDINATION WITH CAFETERIA PLAN

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

6.7 HEALTH CARE REIMBURSEMENT PLAN CLAIMS

(a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to 2.6, 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) 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 Care Reimbursement Fund for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit 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) 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, if a Participant using carryover funds fails to submit a claim by April 30th for Prior Plan Years Medical Expense those claims shall not be considered for reimbursement by the Administrator.*

(d) 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 Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

ARTICLE VII

DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Assistance Program shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

(a) "Dependent Care Assistance Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.

(b) "Dependent Care Assistance Program" means the program of benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for Dependent Care Assistance to the Participant.

(d) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(e)(1) (or deemed to be, as described in Section 7.2(e)(1) pursuant to Section 7.2(e)(3)), or for a Qualifying Dependent as defined in Section 7.2(e)(2) (or deemed to be, as described in Section 7.2(e)(2) pursuant to Section 7.2(e)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Day Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.

(e) "Qualifying Dependent" means, for Dependent Care Assistance Program purposes,

(1) a Dependent of a Participant who is under the age of 13, with respect to whom the Participant is entitled to an exemption under Code Section 15 1(c);

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself, or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Assistance Program benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has selected to apply toward his Dependent Care Assistance Account pursuant to elections made under Article V hereof

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance Account as of the end of *the prior Plan year grace period* (and after the processing of all claims for such Plan Year pursuant to Section 7.12 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.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 2 1(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) It is the intent of this Dependent Care Assistance Program that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are Stakeholders or owners (or their Spouses or Dependents), each of whom (on any day of the plan year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable 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 Dependent Care Assistance Account by the affected participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section 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.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) If a Participant fails to submit a claim within the grace period immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII

BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Any claim for Benefits underwritten by an Insurance Contract shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure. Any other claim for Benefits shall be made to the Administrator. 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. If the Administrator does not notify the Participant of the denial of the claim within the 90 day period specified above, then the claim shall be deemed denied. 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) Within 60 days 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) 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) Any balance remaining in the Participants' Health Care Reimbursement Fund *at the end of a carryover period* or Dependent Care Assistance Account at the end *of the grace period* shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, 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 *aforementioned period* shall be forfeited and credited to the benefit plan surplus.

8.2 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 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 first be used to defray any administrative costs and experience losses and thereafter be retained by the Employer.

ARTICLE IX

ADMINISTRATION

9.1 PLAN ADMINISTRATION

The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan 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 Plan Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

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

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith 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 person to participate in the Plan and to receive benefits provided under 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 under the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits; and

(g) To appoint such agents, counsel, accountants, consultants, and actuaries 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.

9.2 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.

9.3 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.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 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 *as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent, or* occasioned by any act or omission to act in connection with *the performance of their duties, responsibilities, and obligations under the Plan*, if such act or omission is not in good faith.

ARTICLE X

AMENDMENT OR TERMINATION OF PLAN

10.1 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 and regulations *and are formally adopted in writing.*

10.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs. *Any termination or partial termination of the Plan shall not adversely affect the payment of benefits to which a Participant was entitled under the Plan prior to the date of termination or partial termination. If the Plan is terminated, each Participant shall be entitled to benefits for Health Care Reimbursement and Dependent Care Assistant incurred prior to the date of termination, provided that the Participant appropriately follows the terms of this Plan for reimbursement. Thereafter, the Employer* *shall have no liability or obligation to make any reimbursement under the Plan.*

ARTICLE XI

MISCELLANEOUS

11.1 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 11.12.

11.2 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.

11.3 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 Regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

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

11.5 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.

11.6 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.

11.7 EMPLOYER’S PROTECTIVE CLAUSES

(a) Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant’s Benefits shall be limited to the insurance premiums, if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the

Employer or the Participant as a result of the Participant's claim.

(b) The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise or refuse to pursue the claim as the Participant, in his sole discretion, shall see fit.

(c) The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 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.

11.9 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.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall 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.

11.11 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 Georgia. *Benefits provided under this Plan are intended to be exempt from taxation under section 125 and 105 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable to the Plan for the purpose of retaining tax exemption status.*

11.12 INVALID PROVISIONS

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.

11.13 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

11.14 CONTINUATION OF COVERAGE

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.

11.15 FAMILY AND MEDICAL LEAVE ACT

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 Proposed Regulation 1.125-3.

11.16 HIPAA

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with (HIPAA) Health Insurance Portability and Accountability Act and regulations there under.

11.17 UNIFORM SERVICES EMPLOYMENT AND REEMEPLOYMENT RIGHTS ACT

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 USERRA and the regulations thereunder.

IN WITNESS WHEREOF, this Plan document is hereby executed this ____ day of ____________________, _________.

Chatham County – Savannah Metropolitan Planning Commission

By ________________________
EMPLOYER