DeKalb County
Section 125 Cafeteria Plan

Amended and Restated as of July 1, 2022

INTRODUCTION

DeKalb County, Georgia (the “Plan Sponsor”) previously established the DeKalb County Section 125 Cafeteria Plan (hereinafter referred to as the “Cafeteria Plan” or the “Plan”). The purpose of the Plan is to provide employees a choice between certain taxable and nontaxable benefits offered under this and other plans maintained by the Plan Sponsor. Participants may elect to reduce taxable compensation and have the amount of the reduction credited to pay any required contribution for the selected level of coverage under the Plan. The Plan is intended to qualify as a cafeteria plan under Section 125 of the Code and is to be interpreted in a manner consistent with the requirements of that section as it may be amended from time to time.

The Plan Sponsor now amends and restates the Plan in its entirety, effective July 1, 2022 (the “Effective Date”).

The Health Care Spending Account (“HCSA”) component of the Plan is intended to qualify as a self-insured medical reimbursement plan under Section 105 of the Code, and the medical care expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Section 105(b) of the Code. The Dependent Care Spending Account (“DCSA”) component of the Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code, and the dependent care expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Section 129(a) of the Code.

Although included within this document, the HCSA component and the DCSA component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code respectively. The HCSA component is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA. The DCSA component is not subject to ERISA, HIPAA or COBRA.

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ARTICLE I

Definitions

Definitions. As used herein, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context. Words in the masculine gender shall be deemed to include the feminine gender, and words in the feminine gender shall be deemed to include the masculine gender; and unless the context otherwise requires, the singular shall include the plural and the plural the singular. Any headings herein are included for reference only and are not to be construed so as to alter any of the terms of the Plan.

1.01 "Benefit Option" means a qualified benefit under Code Section 125(f) that is offered under a Component Plan, including any separate options for coverage under an underlying accident or health plan, or that is described in Articles V, VI and VII.

1.02 "Change in Status" means any of the following events:

A. An event that changes an Eligible Employee's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

B. An event that changes an Eligible Employee's number of Eligible Dependents, including birth, adoption, placement for adoption, or death of an Eligible Dependent;

C. Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's Spouse or the Eligible Employee's Dependent:

1. A termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence or a change in worksite, or

2. Any other change in employment status that affects an individual's eligibility for benefits under a plan;

D. An event that causes an Eligible Employee's dependent to satisfy or cease to satisfy the definition of Eligible Dependent as set out in the relevant Component Plan; or

E. A change in the place or residence or work of the Eligible Employee, or the place of residence or work of his or her Spouse or Eligible Dependent.

1.03 "Claims Administrator" means the third party designated by the Plan Administrator to determine claims for benefits under the Plan, or in the absence of such designation, the Plan Administrator.

1.04 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, along with any amendments to such law and any pertinent Treasury regulations, rulings, notices or other guidance.

1.05 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

1.06 "Compensation" means a Participant's compensation, as determined by the Employer.

1.07 "Component Plan" means the following Benefit Options maintained by the Employer:

A. A welfare benefit plan maintained by the Employer, including the plan providing reimbursement of eligible health care expenses described in Article V, and a plan otherwise providing benefits permitted to be offered under a Code section 125 cafeteria plan and that is made available under the Plan by the Plan Sponsor;

B. The plan providing dependent care benefits as described in Article VI; and

C. The program providing for contributions to a Health Savings Account as described in Article VII.

All Component Plans are maintained in accordance with one or more documents that are not contained within this Plan document or in accordance with Articles V, VI, and VII of this document.

1.08 "Component Plan Documentation" means the documents that govern the administration of a Component Plan, including, but not limited to, any summary plan descriptions.

1.09 "Dependent Care Spending Account" or "DCSA" means the Benefit Option as described in Article VI.

1.10 "Election Change" means the revocation of an Eligible Employee's election and the making of a new election for the remaining portion of the Plan Year.

1.11 "Election Form" means the enrollment form or other enrollment process (including electronic) authorized by the Plan Administrator by which an Eligible Employee elects benefits for the Plan Year and through which the Eligible Employee may authorize the Employer to reduce his or her Compensation in order to obtain certain benefits.

1.12 "Election Period" means the period designated by the Plan Administrator immediately preceding the beginning of each Plan Year during which the Eligible Employee must complete his or her Election Form.

1.13 "Eligible Employee" means:

A. With respect to each Component Plan, an Employee who is eligible to participate in such plan pursuant to the terms thereof; and

B. With respect to the Benefit Options described in Articles V and VI, an Employee who is regularly scheduled to work at least 20 hours per week throughout the year, and who is not a temporary Employee, as determined by the Employer.

C. With respect to the Benefit Option described in Article VII, an Employee who is enrolled in a Benefit Option that is a high deductible health plan as defined in Section 223(c)(2) of the Code.

1.14 "Eligibility Date" means the earliest of the following:

A. The date an Employee becomes eligible to participate in a Component Plan.

B. For a Benefit Option described in Article V or Article VI of this document, an Eligible Employee's date of hire or, if later, the date the individual first meets the definition of Eligible Employee.

C. For the Benefit Option described in Article VII, the date the Eligible Employee becomes an Eligible Individual as defined in section 7.02 A.

1.15 "Eligible Dependent" means an individual who: (a) is eligible for dependent coverage under a Component Plan (other than a Component Plan described in Article V or Article VI) as the Spouse or dependent of an Eligible Employee, (b) satisfies the definition of Dependent set out in Article V, or (c) satisfies the definition of Qualifying Individual set out in Article VI.

1.16 "Employee" means an individual who performs services for the Employer and is classified as an employee by the Employer (regardless of any retroactive reclassification) while such individual is so classified. Notwithstanding the forgoing, the term "Employee" does not include: (a) leased employees; (b) any employees included in a unit of employees covered by a collective bargaining agreement with the Employer that does not expressly provide for participation of such employees in this Plan; or (c) any nonresident aliens with no U.S. source income.

1.17 "Employer" means the County of DeKalb, Georgia, the Plan Sponsor.

1.18 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.19 "FMLA Leave" means an approved leave of absence protected by the Family and Medical Leave Act of 1993.

1.20 "Health Care Spending Account" or "HCSA" means the Benefit Option as described in Article V.

1.21 "Health Plan" means any Benefit Option providing medical, dental and/or vision care, including any plan offering benefits through a health maintenance organization, that is offered by the Employer and is a Component Plan.

1.22 "Health Savings Account" means the Benefit Option described in Article VII.

1.23 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as it may be amended from time to time and the regulations and interpretations issued thereunder.

1.24 "Military Leave" means a leave of absence protected by the Uniformed Services Employment and Reemployment Rights Act of 1994.

1.25 "Participant" means an Eligible Employee who has coverage under a Benefit Option in effect under this Plan. Except as provided in Section 5.10 B.1., only Eligible Employees may be Participants in this Plan.

1.26 "Plan" means this DeKalb County Section 125 Cafeteria Plan.

1.27 "Plan Administrator" means the Plan Sponsor or any person appointed by the Plan Sponsor to administer the Plan as set forth in Article X.

1.28 "Plan Sponsor" means DeKalb County, Georgia.

1.29 "Plan Year" means the 12-month period beginning each July 1st and ending the next following June 30th.

1.30 "Salary Reduction Contributions" means the amount by which a Participant's Compensation for the Plan Year is reduced and applied to pay for the Participant's share of the cost of coverage under a Component Plan.

1.31 "Similar Coverage" means coverage under the same type of Benefit Option for the same individuals.

1.32 "Spouse" means an individual who is lawfully married to the Employee.

1.33 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the regulations and interpretations issued thereunder.

ARTICLE II

Participation

2.01 Effective Date of Participation

An Eligible Employee will become a Participant in this Plan on his or her Eligibility Date, provided that he or she enrolls for coverage under a Component Plan, as provided in Article IV, within 30 days of the date he or she first becomes an Eligible Employee.

2.02 Termination of Cafeteria Plan Participation

A Participant shall cease to be a Participant on the occurrence of the earliest of the following events:

A. The date this Cafeteria Plan terminates.

B. The date the individual ceases to be covered under any Component Plan, or

C. Except as provided under Section 5.10 B.1., the date the Participant ceases to be an Employee of the Employer.

2.03 Termination of Benefit Option Coverage

Coverage under any Benefit Option elected under this Plan shall terminate on the earlier of:

A. The date so specified in the Component Plan Documentation or in Articles V, VI, and VII of this Plan.

B. The end of the Plan Year. Coverage for subsequent Plan Years can only be obtained in accordance with the election procedures set forth in Sections 4.02 and 4.08.

Notwithstanding the above, a former Participant or other qualified beneficiary, as defined in Section 4980B(g)(l) of the Code, or a former Participant who is on Military Leave may elect to continue coverage under a Component Plan that is a Health Plan beyond the date such coverage would otherwise terminate. The terms and conditions of such continued coverage are set out in the Component Plan Documentation. Contributions to maintain continuation of coverage shall be made directly to the Plan Administrator or insurance carrier as applicable and shall not be made under this Plan, except as otherwise provided under Section 4.09E.1.

ARTICLE III

Contributions

3.01 Salary Reduction Contributions

A. Pre-Tax Salary Reduction Contributions.

1. Except as specified in clause 1. Below, the amount of Salary Reduction Contributions for the Plan Year shall equal the Participant's share of the cost of Benefit Options elected by the Participant, as determined by the Employer and specified during the Election Period for the Plan Year.

2. The amount of Salary Reduction Contributions for the Benefit Options described in Articles V, VI, and VII of this Plan shall be the amount elected for each such Benefit Option by the Participant, subject to the limitations contained in those respective Articles.

3. Salary Reduction Contributions shall be authorized by the Participant through completion of the Election Form. Pre-Tax Salary Reduction Contributions are considered to be contributions made by the Employer on behalf of a Participant.

B. Post-Tax Salary Reduction Contributions.

1. Contributions for any Benefit Options elected by a Participant that covers a Participant's domestic partner shall be on a post-tax basis.

3.02 New Employees

If a new Eligible Employee becomes a Participant after a Plan Year has commenced, the maximum amount of Salary Reduction Contributions made available to such Participant for the balance of the Plan Year (other than Salary Reduction Contributions made pursuant to Articles V, VI or VII) shall be prorated on the basis of the number of pay periods remaining in such Plan Year.

3.03 Pay Reduction and Payroll Withholding

A Participant's Compensation for a Plan Year shall be reduced by the amount of the Pre-Tax Salary Reduction Contributions that the Participant elects for the Plan Year under Section 3.01. Such contributions shall be made only by payroll reduction and shall be authorized by the Participant on the Election Form.

3.04 Contributions by Participants on Approved Non-FMLA Leaves of Absence

A Participant who is on an approved non-FMLA leave of absence and who is otherwise eligible to continue to receive benefits under this Plan while on such leave shall make contributions required

to purchase benefits under the Plan according to the procedures established by the Plan Administrator.

3.05 Contributions by Participants for Coverage Continued During FMLA Leave

A. A Participant who is on a paid FMLA Leave shall have his or her Compensation reduced in the same manner and in the same amount as if he or she was not on such leave

B. Except as provided below, a Participant who continues coverage while on unpaid FMLA Leave shall utilize the "pay-as-you-go" method to pay for such coverage. Under the "pay-as-you-go" method, the Participant pays his or her share of the cost of such coverage by making direct contributions to the Plan on the same schedule as contributions would be made if the Participant was not on leave or under any other payment schedule permitted under 29 CFR §825.210(c), under the Employer's existing rules for payment by Employees on other types of unpaid leave, or under any other system voluntarily agreed to between the Participant and the Employer that is not inconsistent with 26 CFR §1.125-3 or 29 CFR §825.210(c).

C. The Plan Administrator, in its sole discretion, may also permit a Participant to pay for coverage continued during a period of FMLA Leave under either of the following methods of payment:

2. “Pre-pay” method. Under the "pre-pay" method, a Participant pre-pays the amounts due for coverage continued during the FMLA Leave period prior to the commencement of the FMLA Leave, or

3. “Catch-up” method. Under the "catch-up" method, the Participant pays for his or her share of the cost of coverage continued during FMLA Leave after returning from FMLA Leave. This method of payment may be utilized only if the Employer and the Participant agree in advance of the coverage period that:

a. The Participant elects to continue health coverage while on unpaid FMA Leave;

b. The Employer assumes responsibility for advancing payment of the premiums on the Participant's behalf during the FMLA Leave; and

c. These amounts are to be paid by the Participant when the Participant returns from FMLA Leave.

Notwithstanding the above, the Employer may utilize the "catch-up" method to recoup the Participant's share of the cost of continued coverage without obtaining the prior agreement of the Participant under the following circumstances:

a. The Employer chose to continue the Participant's coverage during FMLA Leave and allowed the Participant to discontinue payment of his or her share of the cost of coverage during the duration of such leave; or

b. The Employer continued the coverage of a Participant who had previously elected to continue coverage during FMLA Leave after such Participant failed to make required payments.

C. Basis of Payment. Participant contributions under any method of payment may be made through non-Salary Reduction Contributions made directly by the Participant to the Employer or Component Plan, as the case may be, on an after-tax basis. In addition, the Employer may permit a Participant to pay for coverage through Salary Reduction Contributions as follows:

1. "Pay-as-you-go" method of payment. Payment may be made through Salary Reduction Contributions from taxable compensation due the Participant during the FMLA Leave period.

2. "Pre-pay" method of payment. Payment may be made through Salary Reduction Contributions from any taxable compensation, provided that in the event the period of FMLA Leave spans two Plan Years, pre-payment on a salary reduction basis may not be made for the period of FMLA Leave that falls in the subsequent Plan Year.

3. "Catch-up" method of payment. Payment may be made through Salary Reduction Contributions from any available taxable compensation after the Participant returns from FMLA Leave.

At the Employer's discretion, taxable compensation may also include compensation attributable to unused sick days or unused vacation days.

D. Notwithstanding the above, in no event will the payment methods for Participants on FMLA Leave be offered on terms less favorable as those offered to Participants who are not on FMLA Leave.

ARTICLE IV

Benefit Options and Participant Elections

4.01 Benefit Options

To the extent made available under the Plan by the Plan Sponsor, and subject to all other provisions of this Plan and any other rules for eligibility established by the Plan Administrator, a Participant may choose among the following taxable and nontaxable benefits:

A. Taxable Benefits. The Participant may elect varying amounts of one or more of the following:

1. Compensation.

2. Supplemental group term insurance to the extent it results in imputed income to the Participant under Section 79 of the Code to the extent made available under the Plan by the Plan Sponsor.

3. Health Plan coverage for an otherwise eligible individual who does not qualify for the income tax exclusion for health benefits set out in Section 105(b) of the Code, to the extent available under a Component Plan.

B. Elective Nontaxable Benefits. The Participant may elect one or more of the following Benefit Options to the extent such Benefit Option is made available under the Plan by the Plan Sponsor:

1. Medical coverage, including prescription drug coverage

2. Dental coverage

3. Vision coverage

4. Health Care Spending Account

5. Dependent Care Spending Account

6. Contributions to a Health Savings Account

7. Accidental Death and Dismemberment Insurance coverage

8. Supplemental group term insurance that does result in in imputed income to the Participant under Section 79 of the Code.

4.02 Annual Election Procedures

Prior to the commencement of each Plan Year, the Plan Administrator shall provide an Election Form to each Participant and to each other individual who is eligible to become a Participant at the beginning of the Plan Year. Each Participant or individual eligible to become a Participant shall specify on the Election Form the Benefit Options described in Section 4.01 that are desired for the forthcoming Plan Year and shall also agree to a reduction in his or her Compensation, if applicable, as provided in Article III. The elections made pursuant to the Election Forms shall be effective as of the first day of the Plan Year. Each Election Form must be completed and returned to the Employer on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Plan Year's elections will apply.

4.03 New Employees

If an individual's Eligibility Date is at some time other than at the beginning of a Plan Year, the Plan Administrator will provide such Eligible Employee with an Election Form. Such Eligible Employee may elect one or more of the Benefit Options and/or taxable benefit options described in this Article IV and so specify on the Election Form.

Such Employee must also agree to a reduction in his or her Compensation, if applicable, as provided in Article III. In order to elect a Benefit Option other than Compensation, the Employee must complete and return the Election Form to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's elections will apply.

4.04 Duration of Elections

Except as provided in Section 4.06 and Section 4.09, a Participant's Benefit Option elections are irrevocable and shall remain in effect through the last day of the Plan Year. Such elections shall also be subject to any additional conditions set forth in the Component Plan Documentation.

4.05 Component Plan Enrollment and Participation

Enrollment and participation in any Component Plan offered under this Cafeteria Plan shall be governed by the terms, conditions, and provisions of that Component Plan Documentation.

4.06 Reduction or Revocation of Certain Elections by the Plan Administrator

A. A Participant's election of Salary Reduction Contributions under this Plan may be revoked or reduced at any time prior to or during a Plan Year by the Plan Administrator, to the extent necessary to prevent this Plan from being considered discriminatory under Sections 125(b), 105(h)(2) or 129(d)(2) of the Code.

B. The Plan Administrator may revoke a Participant's election of Salary Reduction Contributions made to a Health Savings Account at any time prior to or during a Plan Year if it determines that such Participant is not an Eligible Individual, as defined in Section 7.02.A.

4.07 Cost of Benefit Options

The Plan Administrator shall determine and set the cost associated with each Benefit Option offered under this Plan. Such cost can be changed at any time prior to or during a Plan Year without prior notification to Participants and the Participants' Salary Reduction Contribution may be changed by the Plan Administrator in accordance with Section 4.09.C.

4.08 Failure to Make an Election

A. Initial Enrollment

Except as otherwise provided in the open enrollment materials for the applicable Plan Year, an Eligible Employee who fails to return a completed Election Form to the Plan Administrator on or before the specified due date for the Plan Year when initially eligible to participate shall be deemed to have elected to receive his or her full Compensation in cash and will have no coverage under any other Benefit Option offered under this Plan.

B. Annual Enrollment

Except as otherwise provided in the open enrollment materials for the applicable Plan Year, a Participant who fails to return an Election Form for any subsequent Plan Year shall be deemed to have: (1) elected to continue whatever Benefit Options (other than HCSA, DCSA, or HSA contributions) he or she had elected on the Election Form most recently filed with the Plan Administrator; (2) elected not to make Salary Reduction Contributions to his or her HCSA, DCSA, and/or HSA and (3) agreed to have his or her Compensation reduced by whatever amount is then necessary to purchase the Benefit Options continued under clause (1), as provided in accordance with Article III of this Plan.

At the discretion of the Plan Administrator, if a Benefit Option in which a Participant had been enrolled is eliminated for the subsequent Plan Year, the Participant may be enrolled in a Benefit Option providing Similar Coverage, if available, as designated by the Plan Administrator or may be permitted to enroll in another Benefit Option. All similarly-situated Participants shall be enrolled in the same Benefit Option.

4.09 Changes in Participant Benefit Option Elections (other than the Health Savings Account)

A. Special Enrollment Rights

A. An Eligible Employee who has special enrollment rights under a group health plan as required under Section 9801(f)(1) and (2) of the Code may make an Election Change with respect to such group health plan coverage, provided the Eligible Employee enrolls himself or herself and/or- his or her Eligible Dependents under a Health Plan Benefit Option that is a group health plan subject to the requirements of HIPAA within 31 days of the occurrence of the event giving rise to such special enrollment rights.

B. An Eligible Employee who has special enrollment rights under a group health plan as required by Section 9801(f)(3) of the Code may make an Election Change with respect to such group health plan coverage provided the Eligible Employee enrolls himself or

herself and/or his or her Eligible Dependents under a Health Plan Benefit Option that is a group health plan subject to the requirements of HIPAA provided also that the Eligible Employee requests enrollment within 60 days of the occurrence of the event giving rise to such special enrollment rights.

C. An Eligible Employee who has special enrollment rights described in this Section 4.09 A. shall be permitted to enroll in any Health Plan Benefit Option available to similarly situated individuals who enroll for coverage when first eligible or, if already enrolled in a Health Plan Benefit Option, to enroll himself or herself and any Eligible Dependents for whom special enrollment rights apply in a different available Health Plan Benefit Option.

B. Changes in Status

1. An Eligible Employee may make an Election Change with respect to the various Benefit Options offered under this Plan following a Change in Status only if such Election Change:

   a. is on account of and is consistent with a Change in Status event that affects eligibility for coverage under an employer's plan or coverage under a particular benefit package option under such plan;

      An Eligible Employee may make an Election Change with respect to the DCSA Benefit Option only if such Election Change is on account of and is consistent with a Change in Status event that affects expenses described in Section 129 of the Code (including employment-related expenses as defined in Section 21(b)(2) of the Code),

   b. is permitted under the terms of the applicable Component Plan Documentation; and

   c. is made within 31 days of the date the Eligible Employee experiences the Change in Status for which the Election Change is permitted.

   Notwithstanding the above, and provided that such action does not violate Section 2712 of the Public Health Service Act as incorporated into Section 715 of ERISA, an Eligible Employee who fails to notify the Plan within 31 days of a Change in Status in which an individual ceases to be an Eligible Dependent under a Component Plan will be deemed to have elected to make an Election Change to cancel such individual's coverage effective on the day on which such individual became ineligible. However, any Salary Reduction Contributions previously made by the Eligible Employee to pay for such individual's coverage during the period beginning on the date coverage terminated and ending on the date the Plan is first apprised of the individual's loss of eligibility shall not be refunded.

2. Special Consistency Rules

   a. Health Coverage. An Election Change to cancel or decrease the coverage of an individual who becomes eligible for coverage under another plan sponsored by the employer of a Participant's family member on account of a change in marital status or

change in employment status will be deemed consistent with a Change in Status only if the individual actually enrolls for such coverage. An Election Change generally will not be deemed consistent with a Change in Status event that is the Participant's divorce, annulment or legal separation from a Spouse, the death of an Eligible Dependent or an Eligible Dependent ceasing to satisfy the eligibility requirements for coverage if it cancels the coverage for any individual other than the affected Spouse and/or Eligible Dependent.

b. Life Insurance and AD&D Coverage. In the case of Life Insurance and AD&D Coverage, either an Election Change to increase coverage or an Election Change to decrease coverage in response to a Change in Status event will be deemed consistent with such Change in Status event.

3. An Eligible Employee who terminates employment during the Plan Year may, upon subsequent reemployment during such Plan Year,

a. Reinstate the elections in effect as of the date employment terminated or,

b. Provided the prior termination of employment was not solely for the purpose of permitting an Eligible Employee to make an Election Change, make an Election Change for the remainder of the Plan Year.

Notwithstanding the above, if a Participant resumes employment as an Eligible Employee within 31 days of the date employment terminated without an intervening event that would otherwise permit an Election Change under this Section 4.09, he or she shall become a Participant on his or her rehire date and the elections in effect as of the date employment terminated shall be reinstated.

C. Changes in Cost

1. Automatic Changes. If the cost of a Benefit Option increases or decreases, including increases or decreases attributable to satisfaction of or failure to satisfy requirements to qualify for a medical premium discount program offered by the Employer, if any, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participant's Salary Reduction Contributions under the Plan.

2. Significant Cost Changes

a. If the cost that a Participant is charged for a Benefit Option significantly increases, the Plan Administrator, in its sole discretion, may permit the Participant to:

(1) Make a corresponding prospective increase in his or her Salary Reduction Contributions;

(2) Revoke the election for that Benefit Option for the balance of the Plan Year and to elect Similar Coverage on a prospective basis; or

(3) Drop coverage if Similar Coverage is not offered.

To be effective, an Election Change must be made within the time specified by the Plan Administrator.

b. If the cost charged for a Benefit Option significantly decreases, the Plan Administrator, in its sole discretion, may:

(1) Permit a Participant who elected coverage under such Benefit Option for the Plan Year to make a corresponding prospective decrease in his or her Salary Reduction Contributions;

(2) Permit all Eligible Employees, including those who elected not to participate in the Plan for the Plan Year, to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the Benefit Option with the decrease in cost on a prospective basis.

(3) Permit Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the Benefit Option with the decrease in cost on a prospective basis.

To be effective, an Election Change must be made within the time specified by the Plan Administrator.

c. In the case of a DCSA, an Election Change is permitted only if the cost change is imposed by a dependent care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related as described in Code Section 152(d)(2)(A)-(G), incorporating the rules of Code Section 152(f)(1). To be effective, an Election Change must be made within 31 days of the date of the cost change.

Notwithstanding the above, this subsection C. does not apply to an Election Change with respect to an HCSA or on account of a change in cost or coverage under an HCSA.

D. Coverage Changes

1. Addition or Significant Improvement in Benefit Option. If a new Benefit Option is added during the Plan Year or if coverage under a Benefit Option is significantly improved during the Plan Year, the Plan Administrator, in its sole discretion, may:

a. Permit all Eligible Employees, including those who elected not to participate in the Plan for the Plan Year, to revoke their elections for the balance of the Plan Year and

to elect to receive coverage under the new or significantly improved Benefit Option on a prospective basis.

b. Permit Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the new or significantly improved Benefit Option on a prospective basis.

To be effective, an Election Change must be made within the time specified by the Plan Administrator.

2. Significant Curtailment with Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that is a loss of coverage, the Plan Administrator, in its sole discretion, may permit the affected Employee to revoke his or her election of such Benefit Option and to elect Similar Coverage on a prospective basis or to drop coverage if no Benefit Option providing Similar Coverage is available. For this purpose, a loss of coverage means a complete loss of coverage under a Benefit Option, including, for example, the elimination of the Benefit Option, an HMO ceasing to be available in the area in which the individual resides or the individual losing all coverage under the Benefit Option by reason of an annual limitation. In addition, the Plan Administrator, in its sole discretion, may treat the following as a loss of coverage:

   a. The withdrawal of a major hospital from a PPO network or a substantial decrease in the physicians participating in a PPO network or HMO;

   b. The reduction in the benefits for which an Employee or Eligible Dependent is currently in a course of treatment.

   c. Any other similar fundamental loss of coverage.

   To be effective, an Election Change must be made within the time specified by the Plan Administrator.

3. Significant Curtailment without a Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that is not a loss of coverage as described in paragraph 2. above, the Plan Administrator, in its sole discretion, may permit the affected Employee to revoke his or her election of such Benefit Option and to elect Similar Coverage on a prospective basis. In no event will the Participant be permitted to drop coverage. For this purpose, coverage under a Benefit Option will be considered significantly curtailed only if there is an overall reduction in coverage provided under the plan generally, such as through a significant increase in the deductible, the copayment or the out-of-pocket cost sharing. To be effective, an Election Change must be made within the time specified by the Plan Administrator.

4. Changes in Coverage under a DCSA

   a. A Participant may revoke his or her prior DCSA election and make a new election that reflects the change in cost of a new dependent care provider. To be effective, an Election Change must be made within 31 days of the date that the new dependent care provider first provides dependent care services.

   b. A Participant may revoke his or her prior DCSA election and make a new election that corresponds with a change in the number of hours of work performed by a dependent care provider. To be effective, the Election Change must be made within 31 days of the date the hours of work are first reduced.

5. Changes in Coverage under Another Employer's Plan

   a. A Participant may make a prospective Election Change that corresponds with an election change made under another employer's plan if the election change made under the other plan was on account of an event for which an Election Change would be permitted under the applicable Treasury Regulations.

   b. A Participant may make an Election Change to drop coverage under a Benefit Option for himself or herself or for his or her Eligible Dependents if the Participant or Eligible Dependents becomes covered under a similar benefit option offered under another employer plan on account of elections made during the other plan's annual enrollment period and if the period of coverage under the other employer plan is different than under this Plan.

   c. A Participant may make an Election Change to enroll for coverage under a Benefit Option for himself or herself or for his or her Eligible Dependents if the Participant or Eligible Dependent drops coverage under a similar benefit option offered under another employer plan on account of elections made during the other plan's annual enrollment period and if the period of coverage under the other employer plan is different than under this Plan.

      To be effective, the Election Change must be made within 31 days of the date the coverage change is made under the other plan.

      Notwithstanding the above, an Election Change is permitted only if it is permitted under the terms of the relevant Component Plan. Any election change to drop coverage will be effective only with respect to those individuals who become covered under the other plan.

6. Loss of Coverage under Other Group Health Coverage. An Eligible Employee may make a prospective Election Change to add coverage for himself or herself, the Eligible Employee's Spouse, domestic partner, and other Eligible Dependents if coverage is lost under group health coverage sponsored by a governmental or educational institution, including the following:

a. A state's children's health insurance program under Title XXI of the Social Security Act;

b. A medical care program of an Indian tribal government, the Indian Health Service or a tribal organization;

c. A State health benefits risk pool; or

d. A foreign government group health plan.

To be effective, the Election Change must be made within 31 days of the date the other coverage is lost.

Notwithstanding the above, this subsection D. does not apply to an Election Change with respect to an HCSA or on account of a change in cost under an HCSA.

E. Other Permissible Changes

1. The Plan Administrator, in its sole discretion, may permit a Participant to elect to increase contributions under the Plan in order to pay for COBRA continuation coverage or state continuation coverage provided under a Health Plan Benefit Option when such coverage is elected by the Participant and/or the Participant's Spouse, or Eligible Dependents, provided they qualify for the income tax exclusion for health coverage under Code Section 105(b).

   To be effective, the election to increase contributions must be made within the period of time provided by COBRA or state law, as applicable, for electing continuation coverage.

2. In the event 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 section 609 of ERISA) requires health coverage for a Participant's child, the Plan may:

   a. Change the Participant's election to provide coverage for the child if the Order requires coverage under the plan maintained by the Employer, or

   b. Permit the Eligible Employee to make an Election Change to cancel coverage for the child if the Order requires another individual to provide coverage and coverage is actually provided.

   To be effective, an Election Change must be made within 31 days of the date the Order is issued to the Employee.

3. Medicare and Medicaid

a. If a Participant or a Participant's Eligible Dependent covered under a Health Benefit Plan Option providing medical benefits enrolls for coverage under Medicare or Medicaid, the Participant may make an Election Change to cancel medical coverage with respect to that individual.

b. If a Participant or a Participant's Eligible Dependent enrolled in Medicare ceases to be eligible for such coverage, the Participant may make an Election Change to enroll the affected individual in medical coverage under a Health Plan Benefit Option as otherwise permitted under the terms of the Component Plan.

To be effective, an Election Change must be made within 60 days of the date the individual enrolls for Medicare or Medicaid as described above or loses eligibility for such coverage, as applicable.

A Participant may. make an Election Change with respect to an HCSA that is consistent with the events set out in this subsection E. To be effective, an Election Change must be made within the period specified for the event.

F. Family and Medical Leave

1. Except as provided in paragraph 2. below, a Participant who goes on unpaid FMLA Leave may:

a. Revoke his or her election under a Health Plan Benefit Option at the onset of such leave or at any time during such leave; and

b. Revoke his or her election with respect to non-health benefits to the same extent as Employees who are on unpaid leaves of absence other than FMLA Leave are permitted to revoke such elections.

Upon return from FMLA Leave, an Eligible Employee who has revoked an election may choose to reinstate such election, provided, however, that the Employer may require reinstatement of the election if Employees who return from a period of unpaid leave not covered by the FMLA are also required to resume participation under a Benefit Option upon return from leave.

2. A Participant shall not be permitted to revoke his or her election if the Employer continues the Participant's coverage while such Participant is on FMLA Leave but allows the Participant to discontinue his or her share of the contributions towards such coverage during the period of FMLA Leave. In such event, the Employer may recover the Participant's share of contributions when the Participant returns to work as provided in Section 3.05.

3. A Participant who is on FMLA Leave shall have the same right to revoke or change elections as described in Section 4.02 and subsections A., B., C., D., and E. of this Section 4.09 as other Employees participating in the Cafeteria Plan who are working and are not on FMLA Leave.

H. Effective Date of Election Changes

An Election Change described in Section 4.09.A that involves the addition of a new dependent through birth, adoption or placement for adoption shall be effective as of the date such dependent was born, adopted or placed for adoption with the Participant. Subject to any limitations on timing for making Election Changes described above, any other Election Change made in accordance with this Section 4.09 shall be effective with the pay period which begins coincident with or immediately following the date the new Election Form is accepted by the Plan Administrator, regardless of when coverage becomes effective under the Component Plan. With respect to the Benefit Options described in Articles V and VI, such changes shall be effective with the pay period which begins coincident with or immediately following the first day of the calendar month in which the Participant makes such Election Change through timely completion of the Election Form.

4.10 Change in Health Savings Account Elections

A Participant may change his or her election of Salary Reduction Contributions directed to a Health Savings Account at any time and for any reason by providing written notice to the Plan Administrator. Such Election Change shall be effective as soon as administratively feasible following the date the Election Form is submitted by the Participant. In the event any Participant becomes covered by Medicare, no further contributions can be made to a Health Savings Account.

ARTICLE V

Health Care Spending Account

5.01 Health Care Spending Account

The Benefit Option described in this Article is intended to qualify as a nontaxable benefit under Section 105(b) of the Code, providing health care benefits to Participants. The provisions of this Article are to be interpreted in a manner consistent with the requirements of Section 105, including but not limited to all non-discrimination provisions, and Section 125 of the Code. All other provisions of this Plan shall apply to, and will govern with respect to, this HCSA Benefit Option, unless expressly contradicted by a provision within this Article or by a provision of any applicable law or regulation.

5.02 Definitions

The following definitions shall apply for the purposes of this Article V:

A. "Debit Card" means a debit card or stored-value card that can be used for the electronic reimbursement of Eligible Expenses from a Participant's HCSA.

B. "Dependent" means an individual who is the Spouse or dependent of the Participant as defined in Section 152 of the Code, without regard to subsections (b)(1), (b)(2) and (d)(1)(B). "Dependent" also means any child (as defined in Section 152(f) of the Code) of the Participant who has not attained age 27 by the end of the Plan Year. For purposes of this Article V, Dependent does not cover a domestic partner or a domestic partner's child (as defined above), unless such child is also the child of the Participant

C. "Eligible Expense" means an expense that meets all of the following requirements:

1. It is an expense for medical care as defined in Section 213(d) of the Code, excluding premiums paid for health coverage, or effective January 1, 2020, is an expense for medical care as defined in Section 106(f) of the Code. Notwithstanding the above, an expense for medicines and drugs (other than insulin) incurred before January 1, 2020 shall qualify as an Eligible Expense only if such medicine or drug was prescribed for the Participant or a Dependent, regardless of whether such medicine or drug was available without a prescription. For this purpose, a prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense was incurred and that was issued by an individual who, on the date the prescription was written, was legally authorized to issue a prescription in that state. Notwithstanding anything herein to the contrary, if a Participant has elected a Health Saving Account, only vision care and dental care expenses are Eligible Expenses.

2. It is incurred by either the Participant or a Dependent.

3. It is not covered, paid for or reimbursed under an insurance policy or any health plan other than this HCSA. In the case of an expense that is partially covered, paid for or reimbursed under an insurance policy or any health plan, the portion not covered, paid for or reimbursed, but for which the Participant or Dependent is liable for and that is an Eligible Expense.

4. It is incurred during the Plan Year or Plan Year Grace Period for which the Participant elected this Benefit Option and while such election is in effect.

5. It is an expense for which adequate substantiation has been provided.

For purposes of subparagraph 4. above, an expense shall be deemed "incurred" as of the date the service is rendered or purchase made, regardless of when it is billed or paid. Provided, however, the Claims Administrator, to the extent permitted by applicable regulations, may treat orthodontia services for which advance payment is made in order to receive such services as incurred at the time such advance payment is made.

D. "Improper Payment" means a payment for a claim that was not properly substantiated as well as a reimbursement of an expense that is later identified as not being an Eligible Expense.

E. "Plan Year Grace Period" means the two and one-half calendar month period immediately following the close of a Plan Year. Notwithstanding the foregoing, the grace period for reimbursement of Eligible Expenses incurred during the Plan Year beginning July 1, 2019 and ending June 30, 2020, shall extend to June 30, 2021.

5.03 Establishment of HCSA

An HCSA shall be established for each Plan Year with respect to each Participant who has elected coverage under the HCSA for such 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 shall be credited to a Participant's HCSA for each Plan Year as Salary Reduction Contributions. A Participant's HCSA for each Plan Year shall be debited from time to time in the amount of any payment pursuant to Section 5.07. A Participant's contributions to the HCSA are made on a pre-tax basis.

5.04 Limitations on Contributions

A. The maximum amount of Salary Reduction Contributions that a Participant may elect to allocate to this Benefit Option for a Plan Year is the amount permitted by Section 125(i)(1) of the Code for such Plan Year. Such amount shall be $2,850 and, at the discretion of and as communicated by the Plan Sponsor, may be increased for a subsequent Plan Year as provided for by Section 125(i)(2) of the Code.

B. Except as provided by Section 3.05 and Section 5.05, the amount of Salary Reduction Contributions for the Plan Year shall be contributed in substantially equal payments throughout the Plan Year. The number of payments shall equal the number of pay periods (as are expected to occur with respect to an individual Participant) in the Plan Year, or portion

thereof, during which the Employee is a Participant in this Plan. The payments shall be made on each pay date during which the individual is a Participant.

C. Subject to the terms of Section 5.06, the maximum benefit payable by this Plan for reimbursement of a Participant's Eligible Expenses shall be equal to the product of (1) the Participant's Salary Reduction Contributions allocated per pay period, and (2) the number of pay periods for which such election is expected to be in effect.

5.05 Limitation on Changes in Elections

A Participant may revoke his or her HCSA election and make a new HCSA election with respect to the remainder of the Plan Year in accordance with the terms of Section 4.09 of this Plan. In the event a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, shall be applicable only to Eligible Expenses incurred after the date the election is effective.

5.06 Limitations on Benefits

No reimbursement shall be made to a Participant with respect to any Plan Year for any expense:

A. That was not an Eligible Expense;

B. That was submitted after the last business day of the third month immediately following the end of the Plan Year (or such other date as determined and communicated by the Plan Administrator); or

C. That, when taken together with prior reimbursements received by the Participant for that Plan Year, exceeds the amount of the Participant's election for the Plan Year in effect on the date such expense was incurred.

D. Incurred by a person other than the Participant or a Dependent as defined in Section 5.02 B.

5.07 Requests for Reimbursement Not Paid with a Debit Card

A. The Participant must request reimbursement of Eligible Expenses by completing the appropriate application form or otherwise provide documentation that includes:

1. Written confirmation from an independent third party, such as an explanation of benefits, invoice, or receipt, that the Eligible Expense has been incurred and the amount of such expense;

2. A written statement or confirmation from the Participant that the Eligible Expense has not been reimbursed or is not reimbursable under any other health plan coverage; and

3. Such other information or documentation as the Claims Administrator may from time to time require.

Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

B. A Participant must submit the application for reimbursement of expenses for a Plan Year no later than the last business day of the third month following the close of the Plan Year in which the Eligible Expenses were incurred (or such other date as determined and communicated by the Plan Administrator). Reimbursement for Eligible Expenses will be made as soon as practical after complete documentation has been submitted by the Participant and approved by the Claims Administrator. In the event of the Participant's death, the Participant's Spouse or domestic partner (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article.

C. Payment of claims shall be made directly to the Participant seeking reimbursement and shall not be made directly to the provider of any services giving rise to such claim.

5.08 Debit Cards

A. The Plan Administrator, in its sole discretion, may permit Participants to access the amounts in their HCSA through a Debit Card. The amount available through the Debit Card shall at all times be limited to the amount of the Participant's HCSA election for the Plan Year reduced by amounts paid or reimbursed for Eligible Expenses incurred during that Plan Year. The Participant must certify before receiving the Debit Card and with each use of the Debit Card that he or she: (1) will use the card only for Debit Card Eligible Expenses, (2) will not use the Debit Card for any medical expense that has already been reimbursed, (3) will not seek reimbursement under any other health plan for any expense paid for with the Debit Card, and (4) will acquire and keep sufficient documentation (including invoices and receipts) for any expense paid with the Debit Card.

B. A Participant may use the Debit Card only at the following merchant categories:

1. A merchant or service provider having a merchant category code that matches that of a health care provider;

2. A "90 percent pharmacy" (defined as a store for which 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in Section 213(d) of the Code; and

3. A merchant that participates in an inventory information approval system that satisfies the requirements of Treasury Proposed Regulation Section 1.125-6(f) or other subsequent guidance.

If otherwise permitted, a Participant may use the Debit Card for the purchase of over-the-counter medicines; provided, however, that on or before December 31, 2019, a Participant

may use the Debit Card for the purchase of over-the-counter prescription drugs only if the conditions of IRS Notice 2011-5 are satisfied.

Payment of an expense with the Debit Card in accordance with the terms of this Section 5.08 shall be deemed to be, and shall be treated as, a reimbursement to the Participant from his or her HCSA. Use of the card in contravention of these terms may constitute fraud upon the Plan and be treated accordingly by the Employer.

C. Payment of an expense with the Debit Card shall be treated as conditional pending receipt of such documentation as the Claims Administrator may require pursuant to Section 5.07, provided, however, that the documentation requirements of Section 5.07 shall not be imposed under the following circumstances unless the Claims Administrator subsequently determines under paragraph D. below that payment of the expense was an Improper Payment:

1. If the claim is for reimbursement of a recurring Debit Card Eligible Expense that matches expenses previously approved as to amount, provider and time period (for example, a claim by a Participant for a co-payment he or she incurs on a regular basis for the same amount), no additional documentation shall be required as a condition of approval of the Debit Card transaction.

2. If the Employer's health plan has co-payments in specific dollar amounts, and the dollar amount of the transaction equals an exact multiple of no more than five times the dollar amount of the co-payment for the specific service, no additional documentation shall be required as a condition of approval of the Debit Card transaction. If the Employer's health plan has multiple co-payments for the same benefit (such as tiered co-payments for pharmacy benefits), and the dollar amount of the transaction equals an exact multiple or combination of the co-payments (but not more than the exact multiple of five times the maximum co-payment), no additional documentation shall be required as a condition of approval of the Debit Card transaction.

3. If a third party independent of the Participant and the Participant's Spouse and Dependents, such as a health care provider, merchant or pharmacy benefit manager provides information at the time and point of sale verifying that the claim is for an expense eligible for payment by a Debit Card and complies with the access, recordkeeping and other requirements of IRS Notice 2011-05, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

4. If the payment is substantiated at the point of sale under an inventory information approval system that matches the inventory control information for the item purchased with a list of items, the purchase of which qualifies as an expense for medical care under Section 213 of the Code and the merchant complies with applicable requirements of IRS Notice 2011-05, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

5.09 Substantiation of Expenses and Recoupment of Improper Payments

A. The Claims Administrator shall establish reasonable procedures for obtaining additional information from a Participant to properly substantiate that an expense is an Eligible Expense, where such additional substantiation is required. A Participant who fails to provide substantiation of an expense within the timeframe specified by the Claims Administrator shall be deemed to have received an Improper Payment in the amount of such expense.

B. If an expense paid with a Debit Card is determined to be an Improper Payment as described in paragraph 1 above, the Claim Administrator shall deactivate the Participant's Debit Card until the amount of the Improper Payment is recovered and notify the Participant of the amount of such Improper Payment. Such notice shall comply with the procedures for denial of a claim under Section 5.14. In addition, the Claim Administrator shall apply the correction procedures set out in Proposed Treasury Regulation Section 125-6(d)(7)(ii) through (iv); such procedures may be applied in any order, provided that such order is consistently applied for all participants. The correction procedure set out in Proposed Treasury Regulation Section 125-6(d)(7)(v) may be applied only after all of the other methods described above have been pursued.

C. Any amounts that are recovered by the Claims Administrator with respect to a Plan Year no later than 90 days after the end of each Plan Year (or such other deadline as the Employer shall establish for the filing of claims) shall be credited to Participant's HCSA for such Plan Year.

5.10 Maintenance of Coverage

A. FMLA Leave

1. A Participant who is on an unpaid FMLA Leave may choose to maintain his or her coverage under the HCSA Benefit Option for the duration of his or her FMLA Leave at the level and under the conditions that such coverage would have been provided if he or she had continued in active employment. The Participant's right to maintain such coverage will terminate when:

   a. The Participant terminates employment by either notifying the Employer that he or she does not intend to return from FMLA Leave or by failing to return from FMLA Leave when such leave is exhausted,

   b. The Participant's employment would have terminated and coverage would have been lost if he or she had not taken FMLA Leave as the result of lay-off or the down-sizing of the Employer; or

   c. The Participant fails to make a required contribution for such coverage, if any, within the later of 31 days of the date due or 15 days after the Employer notifies the Employee that his or her coverage will end for failure to make required contributions. Coverage shall cease as of the last day of the period for which the last contribution was made.

2. Participant contributions for continuing coverage under the HCSA shall be made in accordance with the terms and conditions of Section 3.05.

3. At the expiration of the FMLA Leave, a Participant whose coverage had ceased either because he or she had revoked his or her HCSA election pursuant to Section 4.09 or because he or she had failed to make required contributions shall resume coverage by making contributions to his or her HCSA. To the extent required by law, the Participant shall be given the choice between:

   a. Resuming coverage at the level in effect immediately prior to his or her FMLA Leave and making up any contributions that were not made during the FMLA Leave, or

   b. Resuming coverage at a level that is reduced on a pro rata basis for the period during the FMLA Leave for which no contributions were made with contributions due in the same monthly amount payable immediately prior to FMLA Leave.

   In both instances, the coverage level shall be reduced by prior reimbursements.

4. In no event shall a Participant receive reimbursement for Eligible Expenses incurred while coverage under the HCSA was not in effect.

Nothing in this section shall affect the Employer's obligation to provide for continuation of coverage under Sections 2.03 and 5.13 B. of the Plan, nor shall it affect the Participant's right to make a new election during annual enrollment or to revoke or change elections as provided under Section 4.09.

B. Continuation under COBRA and USERRA

1. COBRA

   a. A former Participant or other qualified beneficiary, as defined in Section 4980B(g)(1) of the Code, who has a qualifying event during a Plan Year as set out in Section 4980B(f)(3) of the Code and has “underspent” his or her HCSA at the time coverage would otherwise end may continue coverage under the HCSA under COBRA. For this purpose, a qualified beneficiary will be deemed to have “underspent” his or her HCSA if the HCSA balance at the time participation would otherwise end is less than the amount of the premiums, including any applicable administrative fees, that the qualified beneficiary would be required to pay to continue to participate in the HCSA under COBRA for the remainder of the Plan Year.

   Coverage under and HCSA that qualifies as an “excepted benefit” under Treasury Regulation §54.9831-1(c)(3)(v) may be continued for the remainder of the Plan Year in which the qualifying event occurs. Coverage under an HCSA that does not qualify as an “excepted benefit” under Treasury Regulations §54.9831-1(c)(3)(v) may be continued as provided in Section 4980B(f)(2) of the Code.

b. To continue coverage under COBRA, a Participant must make direct and timely contributions to the Employer. The amount of the contributions may be subject to a surcharge in the sole discretion of the Plan Sponsor, but shall not exceed the maximum permitted under applicable federal law. To the extent required by COBRA, and as permitted by Section 125 of the Code, a qualified beneficiary who has elected to exercise his or her continuation of coverage rights under COBRA shall be treated as a Participant under the Plan. If continuation coverage is elected, coverage shall be maintained, and Eligible Expenses shall be reimbursed as provided in this Article V.

2. Military Leave

a. A Participant who is on Military Leave may elect to continue his or her coverage under the HCSA beyond the date such coverage would otherwise terminate by making direct and timely contributions to the Employer for the period during which such coverage is required to be maintained under USERRA. Continuation of coverage under this paragraph 2. shall run concurrently with the continuation of coverage provided in paragraph 1. The amount of the contributions shall not exceed the maximum permitted under applicable federal law. To the extent required by USERRA, and as permitted by Section 125 of the Code, a qualified beneficiary who has elected to exercise his or her continuation of coverage rights under USERRA shall have the same rights as a Participant under the HCSA who has not gone on Military Leave. If continuation coverage is elected, coverage shall be maintained and Eligible Expenses shall be reimburses as provided in this Article V.

3. If an election to continue coverage under this provision is not made, coverage under the HCSA will terminate on the last day of the pay period for which a required contribution was made. Reimbursement shall be made only for Eligible Expenses incurred prior to the date coverage under the HCSA terminated and only if a request for reimbursement is made as provided in Sections 5.07 and 5.08.

No such reimbursement shall exceed the amount of the Participant's election for the Plan Year on the day the Eligible Expenses were incurred less prior reimbursements for such Plan Year.

4. The right of a Participant or other qualified beneficiary to continuation coverage under COBRA shall terminate effective as of the last day of the Plan Year in which the qualifying event occurs, or, if earlier, on the date one of the events specified in Section 4980B(f)(2)(B)(ii) or (iii) of the Code occurs. The rights of a Participant beneficiary to continuation coverage under USERRA shall terminate on the earlier of the date such coverage is terminated for failure to pay a required premium or such coverage is no longer required to be maintained under USERRA.

5.11 Forfeitures

Any balance attributable to Salary Reduction Contributions for any given Plan Year remaining in a Participant's account on the last business day of the third month immediately following the end of the Plan Year in which such contributions were made (or such other date as determined and

communicated by the Plan Administrator) will be forfeited, as soon as practicable after the period of time necessary for the Claims Administrator to give due consideration to all requests for reimbursement.

In the event that the total amounts credited to all HCSAs for a Plan Year exceed total reimbursements for such Plan Year, the excess amounts shall not be retained by the Employer, but shall be: (1) used to defray reasonable administrative expenses; (2) applied to reduce Employee contributions for the next Plan Year; and/or (3) returned to Participants on a per capita basis; provided however, that in no event will contributions be returned or allocated to a Participant on the basis of the amounts that were forfeited by such Participant and provided, further, that such allocations shall be made in a nondiscriminatory manner.

In the event a Participant fails to present a reimbursement check for payment within 18 months of issuance, the benefits represented by such check shall be forfeited. Such forfeited amounts shall be applied toward the administrative expenses of the Plan or shall revert to the Employer.

5.12 Mandatory Reduction of Contributions

The Plan Administrator retains the right to reduce any Participant's allocation of Salary Reduction Contributions to this account in accordance with the terms of Section 4.06 of this Plan.

5.13 Statements

Each Participant who has had contributions made to an HCSA for the Plan Year shall be furnished with a written statement showing a reasonable estimate of the amount of Eligible Expenses reimbursed from the account in accordance with applicable provisions of this Plan with respect to such Plan Year.

5.14 Claims and Appeals Procedures

The claims and appeals procedures for the HCSA are described in the Component Plan Documentation for the DeKalb County health plan.

ARTICLE VI

Dependent Care Spending Account

6.01 Dependent Care Spending Account

The Benefit Option described in this Article VI is intended to qualify as a nontaxable employee benefit under Section 129(a) of the Code, providing dependent care assistance benefits to Participants. The provisions of this Article are to be interpreted in a manner consistent with the requirements of Sections 125 and 129 of the Code, including but not limited to any non-discrimination provisions thereunder. All other provisions of this Plan shall be applied to, and will govern with respect to, this DCSA, unless expressly contradicted by a provision within this Article or by a provision of any applicable law or regulation.

6.02 Definitions

The following definitions shall apply for the purposes of this Article VI:

A. "Applicable Statutory Limit" means the smallest of the following:

1. The amount specified in Section 6.04 as determined by the Participant's marital and filing status;

2. The Participant's earned income for the calendar year; or

3. If the Participant is married at the end of the calendar year, the Spouse's earned income for such calendar year, provided, however, that the earned income of a Spouse who is a student or incapable of self-care shall be determined as provided in Section 21(d)(2) of the Code.

For purposes of this definition, "earned income" shall have the meaning set out in Section 129(e)(2) of the Code.

B. "Dependent" means a "qualifying individual" as defined in Section 21(b)(1) of the Code.

C. "DCSA Balance" means the contributions allocated to the Participant's DCSA as of the last day of the pay period ending immediately before the date the expense is submitted.

D. "Eligible Expense" means an expense that meets each of the following requirements:

1. It is considered employment-related expenses as defined in Section 21(b)(2) of the Code and the regulations thereunder.

2. It is for services incurred during the Plan Year or Plan Year Grace Period for which the Participant elected this Benefit Option and while such election is in effect.

3. It is an expense for which the Participant has provided adequate substantiation.

For purposes of subparagraph 2 above, an expense shall be deemed "incurred" as of the date the service is rendered regardless of when the Participant was actually billed or paid for the expense.

F. "Plan Year Grace Period" means the two and one-half calendar month period immediately following the close of a Plan Year. Notwithstanding the foregoing, the grace period for reimbursement of Eligible Expenses incurred during the Plan Year beginning July 1, 2019 and ending June 30, 2020, shall extend to June 30, 2021.

6.03 Establishment of DCSA

A DCSA shall be established for each Plan Year with respect to each Participant who has elected to receive the DCSA Benefit Option for such 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 shall be credited to a Participant's DCSA for each Plan Year as Salary Reduction Contributions. A Participant's DCSA for each Plan Year shall be debited from time to time in the amount of any payment under Section 6.08. A Participant's contributions to the HCSA are made on a pre-tax basis.

6.04 Limitations on Contributions

The maximum amount of Salary Reduction Contributions that a Participant may elect to allocate to this benefit is $5,000 for any Plan Year (or $2,500 in the case of a married Participant who is married filing "separately" with regard to the Internal Revenue Service Form 1040). The Plan Administrator may limit contributions for highly-compensated participants as it deems necessary to comply with nondiscrimination requirements of the Code.

6.05 Timing of Contributions

Except as may be permitted under Section 4.09, the amount of Salary Reduction Contributions for the Plan Year shall be contributed in substantially equal installments during the Plan Year. The number of installments shall equal the number of pay periods in the Plan Year, or portion thereof, during which the Employee is a Participant in this Plan. The installments shall be made on each pay date during which the individual is a Participant.

6.06 Limitation on Changes in Elections

A. A Participant may revoke his or her DCSA election and make a new DCSA election with respect to the remainder of the Plan Year in accordance with the terms of Section 4.09 of this Plan. In the event a Participant makes a new election, the amount of the new election,

reduced by the amount of prior reimbursements for that Plan Year, shall be applicable only to Eligible Expenses incurred after the date the election is effective.

B. A Participant may revoke his or her DCSA election on a retroactive basis during the Plan Year if at the time of the election and at all times thereafter, the Participant did not have a Dependent, as defined in Section 6.02 B. above and the election clearly was based on a mistake of fact, as determined by the Plan Administrator.

6.07 Limitations on Benefits

No reimbursement shall be made to a Participant with respect to any Plan Year for any expense:

A. That was not an Eligible Expense;

B. That was submitted after the last business day of the third month immediately following the end of the Plan Year (or such other date as determined and communicated by the Plan Administrator);

C. That is not eligible for reimbursement according to all the provisions and restrictions of Sections 129 and 21 of the Code; or

D. That exceeds the lesser of the following:

1. The amount of the Participant's election for the Plan Year in effect on the date such expense was incurred reduced by the amount of prior reimbursements made for that Plan Year.

2. The current amount of the Participant's DCSA.

In the event the expense for which reimbursement is sought exceeds subparagraph 2. but not subparagraph 1., the amount of the expense in excess of subparagraph 2. will be held for future reimbursement consideration within that current Plan Year.

In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the amount of prior reimbursements made for that Plan Year, would exceed the Participant’s Applicable Statutory Limit.

6.08 Requests for Reimbursement

A. A Participant must request reimbursement of Eligible Expenses by completing the appropriate application form that includes:

1. A written statement from an independent third party stating that the Eligible Expense has been incurred and the amount of such expense;

2. The name and address and social security number or tax identification number of the person, organization or entity to whom the Eligible Expense was or will be paid, or in the case of an organization exempt from tax under Section 501(c)(3) of the Code, the name and address of such organization; and

3. Such other information as the Claims Administrator may from time to time require.

The request shall be accompanied by bills, invoices, receipts or other statements or certifications showing the amounts of such expenses, together with any additional documentation that the Claims Administrator may require. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

B. A Participant must submit the application for reimbursement of expenses for a Plan Year no later than the last business day of the third month following the close of the Plan Year in which the Eligible Expenses were incurred (or such other date as determined and communicated by the Plan Administrator). Reimbursement will be made for Eligible Expenses as soon as practical after complete documentation has been submitted by the Participant and approved by the Claims Administrator. In the event of the Participant's death, the Participant's Spouse (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article.

6.09 Termination of Coverage

Coverage under this Dependent Care Spending Account Benefit Option for a Participant who ceases to be an Eligible Employee will terminate as of the last day of the period for which appropriate contributions for coverage were made.

Notwithstanding the above, the Plan Administrator, in its sole discretion and on a nondiscriminatory basis, may permit a terminated Participant to continue to submit Eligible Expenses incurred during the Plan Year for reimbursement; claims shall be reimbursed to the extent they do not exceed the balance credited to a Participant's DCSA at the time the request for reimbursement is processed.

An individual whose participation has terminated shall have until the last day of March following the Plan Year in which his or her coverage was terminated to submit Eligible Expenses for reimbursement.

6.10 Maintenance of Coverage

A. A Participant who is on FMLA Leave may maintain coverage under the DCSA Benefit Option to the same extent as if he or she had continued in active employment. Participant contributions to maintain coverage shall be made under the terms and conditions of Section 3.05, provided, however, that in the event the Participant fails to make the contributions described in Section 6.05 in the manner provided in Section 3.05, coverage shall cease as of the last day of the period for which the last contribution was made. A Participant whose

coverage has ceased for failure to make contributions may be reimbursed for Eligible Expenses incurred after the date coverage ends only as provided in Subsection A. above.

B. Upon the expiration of the FMLA Leave, a Participant whose coverage had ceased for failure to make contributions may resume coverage by making contributions to his or her DCSA. Unless the Participant has made a new election in accordance with Section 4.09, the Participant's election in effect prior to his or her FMLA Leave shall remain in effect, but prorated to reflect the period of non-participation and the amount of his or her contributions shall be determined pursuant to Section 6.05.

6.11 Forfeitures

Any balance attributable to Salary Reduction Contributions for any given Plan Year remaining in a Participant's account on the last business day of the third month immediately following the end of the Plan Year in which such contributions were made (or such other date as determined and communicated by the Plan Administrator) will be forfeited as soon as practicable after the period of time necessary for the Claims Administrator to give due consideration to all requests for reimbursement.

In the event that the total amounts credited to all DCSA for a Plan Year exceed total reimbursements for such Plan Year, the excess amounts may be retained by the Plan Sponsor or, may be: (1) used to defray reasonable administrative expenses; (2) applied to reduce Employee contributions for the next Plan Year; and/or (3) returned to Participants on a per capita basis; provided however, that in no event will contributions be returned or allocated to a Participant on the basis of the amounts that were forfeited by such Participant and provided, further, that such allocations shall be made in a nondiscriminatory manner.

In the event a Participant fails to present a reimbursement check for payment within 18 months of issuance, the benefits represented by such check shall be forfeited. Such forfeited amounts shall be applied toward the administrative expenses of the Plan or shall revert to the Employer.

6.12 Mandatory Reduction of Contributions

The Plan Administrator retains the right to reduce any Participant's allocation of Salary Reduction Contributions to this account in accordance with the terms of Section 4.06 of this Plan.

6.13 Statements

Each Participant who has had contributions made to a DCSA during the Plan Year shall be furnished with a written statement showing a reasonable estimate of the amount of Eligible Expenses reimbursed from the account in accordance with applicable provisions of this Plan with respect to such Plan Year.

6.14 Claims Procedures

The Plan Administrator shall determine all claims and appeals in accordance with its established procedures and its decision shall be final and binding on all parties.

ARTICLE VII

Contributions to Health Savings Accounts

7.01 Health Savings Account Contributions

The Benefit Option described in this Article is intended to qualify as a nontaxable benefit under Code Section 223, providing for contributions to a Health Savings Account ("HSA") on behalf of Participants who are enrolled in a Benefit Option that qualifies as a "high-deductible health plan," as defined in Section 223(c)(2) of the Code ("HDHP"). The provisions of this Article are to be interpreted in a manner consistent with the requirements of Code Section 125 and Code Section 223. All other provisions of this Plan shall be applied to, and will govern with respect to, this Health Savings Account Benefit Option, unless expressly contradicted by a provision within this Article or by a provision of any applicable law or regulation.

7.02 Definitions

A. "Eligible Individual" means a Participant who (i) is covered by a Benefit Option that qualifies as an HDHP as of the first day of a month, and (ii) who has no coverage under any health plan that is not an HDHP, other than certain coverage permitted under Code Section 223(c)(1)(B).

B. "Employer HSA Contributions" means the contributions made by the Employer, if any, to a Participant's HSA that are not attributable to Salary Reduction Contributions.

C. "HSA Provider" means the bank or other HSA provider with which the Employer has contracted to forward contributions made by or on behalf of Eligible Individuals enrolled in an HDHP sponsored by the Employer.

D. "High Deductible Health Plan" ("HDHP") shall mean a group health plan that satisfies the requirements of Code Section 223(c)(2).

7.03 Election of Contributions

A Participant who qualifies as an Eligible Individual during a month may direct that Salary Reduction Contributions be made to an HSA established with an HSA Provider. Subject to Section 7.05, a Participant may change the amount of Salary Reduction Contributions to be made to his or her HSA as set out in Section 4.10.

7.04 Employer HSA Contributions

The Employer may make Employer HSA Contributions to an HSA established on behalf of a Participant with an HSA Provider. The amount, if any, and timing of such Employer HSA Contributions for a Plan Year shall be communicated to Eligible Employees prior to the start of the applicable Plan Year. Any Employer HSA Contributions shall be made on a nondiscriminatory basis on behalf of all similarly situated Participants.

7.05 Annual Limit on HSA Contributions

A. The maximum amount that may be contributed to a Participant's HSA (including any Employer HSA Contributions) shall equal the sum of the "monthly limitation" for each month during such Plan Year in which the Participant was covered by the HDHP. The "monthly limitation" for any such month is one-twelfth (1/12) of: (i) in the case of a Participant who has self-only coverage under the HDHP as of the first day of such month, the dollar amount specified in Code Section 223(b)(2)(A), adjusted to reflect changes in the cost-of-living, in accordance with guidance issued by the Secretary of the Treasury; or (ii) in the case of a Participant who has family coverage under the HDHP as of the first day of such month, the dollar amount specified in Code Section 223(b)(2)(B), adjusted to reflect changes in the cost-of-living, in accordance with guidance issued by the Secretary of the Treasury. In the case of any Participant who attains age 55 before the close of the Plan Year, the applicable dollar amounts specified in clauses (i) or (ii) above shall be increased by $1,000.

B. Solely for computing the contribution limitation under subsections (i) and (ii) above, a Participant who is an Eligible Individual on December 1st of a Plan Year may be treated as having been an Eligible Individual during each month of such Plan Year and as having been enrolled in the same HDHP coverage in which he or she was enrolled on December 1st during each month in which he or she is treated as an Eligible Individual solely by reason of this provision.

7.06 Participant Responsibility Regarding HSA Eligibility and Contributions

A Participant who is contributing to an HSA under the Plan shall inform the Plan Administrator if he or she at any time ceases to be an Eligible Individual. The Participant shall also be responsible for determining whether, and to what extent, his or her own HSA contributions under this Plan must be reduced for a period on account of contributions to any other health savings account or Archer medical savings account ("Archer MSA") or on account of any "qualified HSA funding distribution," as described in Code Section 408(d)(9). The Plan Administrator shall have no duty to investigate whether a Participant has coverage under another employer's non-HDHP plan, another health savings account, Archer MSA or whether such Participant has made a "qualified HSA funding distribution".

7.07 Excess HSA Contributions

A. In the event that the Employer has notice prior to the end of the Plan Year that contributions made to a Participant's HSA under this Plan exceed the applicable limits specified in Section 7.04 because the Participant is not, or has ceased to be, an Eligible Individual, it shall, to the extent possible, include such excess contributions in reporting the Participant's income for such Plan Year and withhold any applicable taxes on such excess contribution, but shall not be responsible for taking any other corrective action. Provided, further, that neither the Employer nor the Plan Administrator shall have other responsibility with respect to excess contributions made to a Participant's HSA.

B. The Plan Administrator shall have no duty to determine whether any HSA distribution is taxable or nontaxable or subject to an additional tax under Code Section 223.

ARTICLE IX

Amendment or Termination

8.01 Amendment and Termination

Although it is intended that the Plan will be maintained for an indefinite period of time, the Plan Sponsor, by action of its Board of Directors or its authorized delegate, at any time and for any reason may amend or terminate (retroactively if necessary or appropriate) the Plan, or any Benefit Option or feature of the Plan, including, but not limited to: (a) the amount of premiums and/or extent of coverage with respect to any benefit or feature of the Plan for all or for any group or class of Participants, and (b) the categories of individuals eligible to be Participants with respect to any Benefit Option or feature of the Plan.

ARTICLE X

Administration

9.01 Plan Administrator

The Plan Administrator's principal duty shall be 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 among them.

9.02 Powers and Duties

The Plan Administrator shall 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 discretionary authority, in addition to all other powers provided by this Plan:

A. To establish a funding policy and method consistent with the objectives of the Plan and as required by law.

B. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law.

C. To interpret the Plan, its interpretation in good faith to be final and conclusive on all persons claiming benefits under the Plan.

D. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan.

E. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan.

F. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, including, but not limited to, delegating certain claims administration duties to a claims administrator, provided that any such allocation, delegation or designation shall be set out in a written instrument executed by the Plan Administrator and the designated party.

G. To communicate to any insurer or other supplier or administrator of benefits under this Plan in writing all information required to carry out the provisions of the Plan.

H. To notify the Participants in writing of any substantive amendment or termination of the Plan or of a change in benefits available under the Plan.

Notwithstanding the provisions of this section, the powers and duties allocated to the Plan Administrator and described in this section shall only be applicable with respect to a claim arising under the Benefit Options or to the administration of the Benefit Options to the extent that such power or duty is not allocated (either expressly or by implication) to the individual(s) or entity appointed to serve as administrator of any of the Benefit Options.

9.03 Examination of Records

The Plan Administrator will make available to each Participant such records under the Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

9.04 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions of, the administrators of any of the Component Plans, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

9.05 Nondiscriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

9.06 Standard of Review

The Plan Administrator shall perform its duties as the Plan Administrator and shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

ARTICLE XI

Miscellaneous Provisions

10.01 Exclusive Benefit

The assets of the Plan, if any, will not be diverted to or used by the Company for purposes other than the exclusive benefit of participants and beneficiaries, except to pay the administrative expenses of the Plan.

10.02 Status of Participants

No participant will have any right or claim to any benefits under the Plan except in accordance with the provisions of the Plan. The adoption of the Plan will not be construed as creating any contract of employment between the Employer and any participant or to otherwise confer upon any participant or other person any legal right to continuation of employment, or as limiting or qualifying the right of the Employer to discharge any participant without regard to any effect the discharge might have upon the participant's rights under the Plan. Except for the right to receive a benefit for claims incurred under the terms of the Plan, nothing contained in this Plan will be construed as giving any participant, employee, or beneficiary an equity or other right, title or interest in any benefits or in any of the assets, business, or affairs of the Company because of the Plan.

10.03 Information to be Furnished.

Participants shall provide the Employers and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering of the Plan.

10.04 Governing Law

This Plan shall be construed, administered and enforced according to the laws of Georgia except as may be preempted by federal law.

10.05 Severability of Provisions

If any provision of the Plan is declared void and unenforceable, the other provisions may be severed and will not be affected thereby and to the extent that the Plan will ever be in conflict with, or silent with respect to, the requirements of any other law or regulation, the provisions of the law or regulation will govern. In the administration of the Plan, the Plan Administrator may avail itself of any permissive provisions of any applicable law or regulation that are not contrary to the provisions of this Plan.

10.06 Construction and Interpretation.

The Plan will be interpreted to maintain the tax qualification and tax benefits for the Company and Plan participants and to be consistent with the express purpose and intention of the Plan.

10.07 Facility of Payment

Payment of Plan benefits may be made on behalf of any person, including payment to an organization that has made payment to the person, when deemed expedient by the Plan Administrator to satisfy the intent of the Plan, and payment so made will discharge the liability of the Plan.

10.08 Lost Payee

Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward the administrative expenses of the Plan, or shall revert to the Plan Sponsor. If, within two (2) years after any amount becomes payable hereunder to a Participant, the same shall not have been claimed, the amount thereof shall be forfeited and shall cease to be a liability of the Plan, provided due and proper care shall have been exercised by the benefits committee in attempting to make such payment. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

10.09 No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the Employer neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's Compensation is reduced pursuant to Article III will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to notify the Employer if the Participant has reason to believe that any payment made or to be made to the Participant pursuant to the Plan is not excludable from the Participant's gross income for federal, state or local income tax purposes.

10.10 Funding

Except as otherwise required by law: (a) any amount contributed by a Participant and/or the Employer to provide benefits under the Plan shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer; (b) the Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under the Plan, provided, however, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under the Plan; and (c) no person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

10.11 Indemnification of Employer by Participant

If a Participant in the HCSA and/or DCSA Benefit Option receives one or more payments in accordance with applicable Plan provisions that are not for Eligible Expenses, as defined in

Articles V and VI. such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from such payments. Such indemnification and reimbursement shall not exceed the sum of the amount of additional federal and state income tax that the Participant would have owed if the payments 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.

ARTICLE XII

HIPAA Privacy and Security Compliance

11.01 Definitions

A. "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

B. "Individually Identifiable Health Information" is information that is a subset of health information, including demographic information collected from an individual, and

1. Is created or received by this Plan; and

2. Relates to the past, present, or future physical or mental health or conditions of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

a. That identifies the individual; or

b. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

C. "Protected Health Information" means Individual Identifiable Health Information that is transmitted or maintained in any form or medium but excluding Individual Identifiable Health Information in:

1. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 United States Code ("USC") Section 1232g;

2. Student records described at 20 USC Section 1232g (a)(4)(B)(iv); or

3. Employment records held by the Plan Sponsor in its role as an employer.

D. "Summary Health Information" means information that summarizes claims history, expenses, or types of claims by individuals for whom the Plan Sponsor provides benefits under the Plan, and from which individual identifying information has been removed in the manner described in 45 CFR 164.514.

11.02 Plan Status

The Plan provides welfare benefits that are not health care benefits and, as a result, generally are not subject to HIPAA's privacy and security requirements. Notwithstanding any other provision of the Plan, this Article applies only to the health care spending account (Article V) component of the Plan.

11.03 Interpretation/Subsequent Legislation

This Article is intended to comply with the requirements of Title II of HIPAA and applies to this Plan only to the extent that Title II of HIPAA applies to this Plan. In the event of any conflict between the terms of this article and Title II of HIPAA, this Plan shall be administered in the manner necessary or appropriate to comply with Title II of HIPAA. For example, to the extent that any of the following sections of this article are not consistent with the requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") or the American Recovery and Reinvestment Act of 2009, that section will be deemed to have been amended in order to be in compliance with such act.

11.04 Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests such information for the purpose of obtaining premium bids for obtaining health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

11.05 Electronic Protected Health Information

The Plan Sponsor further agrees that if it creates, receives, maintains or transmits any Electronic Protected Health Information (other than enrollment, disenrollment and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health Information, and it will ensure that any agents (including subcontractors) to whom it provides such Electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor will report to the Plan any security incident of which it becomes aware.

11.06 Disclosures to the Plan Sponsor for Plan Administration Purposes

The Plan will disclose Protected Health Information to the Plan Sponsor only in accordance with 45 CFR Section 164.500 et. seq. and the provisions of this Article. Unless otherwise permitted by law, the Plan may disclose Protected Health Information to the Plan Sponsor for Plan administration purposes. Plan administration purposes include but are not limited to the following:

A. Claims processing;

B. Quality assurance;

C. Auditing;

D. Eligibility and coverage determinations;

E. Coordination of benefits adjudication and subrogation of health claims;

F. Obtaining payment under contracts for re-insurance;

G. Management of payment and health care operations; and

H. Assessment of plan payment and health care operations and evaluation of proposed changes to payment and health care operations.

11.07 Conditions of Disclosure for Plan Administration Purposes

Other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a signed authorization, the Plan Sponsor will:

A. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents, or as required by law;

B. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

C. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

D. Report to the Plan any use or disclosure of Protected Health Information that it becomes aware of that is inconsistent with the Plan, applicable law or the applicable Notice of Privacy Practices;

E. Make available Protected Health Information in accordance with 45 CFR 164.524, detailing a participant's right of access to Protected Health Information; make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR 164.526, detailing participant's rights to amend their Protected Health Information; and make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528;

F. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR Part 164. Providing this information to the Secretary will not waive any attorney-client, accountant-client, or other legal privilege or the work product rule;

G. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor continues to maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, the Plan Sponsor will limit future use and disclosures of it to those purposes that meet the requirements of applicable law and make the return or destruction of the information infeasible;

H. Ensure that adequate separation between the Plan and the Plan Sponsor is maintained as follows:

1. The Plan Sponsor will limit disclosure of and access to Protected Health Information to the individuals or classes of employees identified in the HIPAA policy adopted by the Plan Sponsor and any other employee who needs access to Protected Health Information in order to perform Plan administrative functions.

2. The Plan Sponsor will restrict the access to and use by the persons described above, to the Plan administration functions that the Plan Sponsor performs for the Plan.

3. The Plan Sponsor will ensure that the provisions of this subsection H are supported by reasonable and appropriate security measures to the extent that the designees have access to Electronic Protected Health Information.

4. The Plan Sponsor will provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Article by persons described above.

5. The Plan Sponsor will review and where appropriate, discipline, all instances of alleged violation of the rules of this Article in accordance with the Plan Sponsor's employee discipline and separation of employment policies.

I. The Plan Sponsor further agrees that if it creates, receives, maintains or transmits any Electronic Protected Health Information (other than enrollment, disenrollment and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information;

2. Ensure the adequate separation between the Plan and the Plan Sponsor, as required by 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

3. Ensure that any agents (including subcontractors) to whom it provides such Electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect the information; and

4. Report to the Plan any security incident of which it becomes aware.

11.08 Certification

The Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan documents have been amended to incorporate the requirements described in Section 10.7.

11.09 Organized Health Care Arrangement

A health insurance issuer or health maintenance organization providing benefits to participants in the Plan may disclose Protected Health Information to the Plan Sponsor and the Plan as permitted in this Article if a Notice of Privacy Practices is maintained and provided as required by 45 CFR 164.520.

11.10 Genetic Information

The Plan will not use or disclose Protected Health Information that is genetic information, as defined in 45 CFR §160.103, for determining eligibility (including enrollment and continued eligibility), the computation of premium or contribution amounts, the application of any pre-existing condition exclusion or other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

* * * * *

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and on its behalf by its duly authorized delegate as of the ___9th_____ day of __August_, 2023___.

DeKalb County, Georgia

By: *Larry Jacobs*

Its: Assistant Finance Director