LIVINGSTON COUNTY

FLEXIBLE BENEFITS PLAN

TABLE OF CONTENTS

Article 1
Introduction

1.1 Purpose of Plan

The Employer has adopted this Plan to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for eligible Employees and their dependents and beneficiaries. The Plan is designed to permit eligible Employees to choose among certain nontaxable and taxable benefits (including cash).

1.2 Plan Status

This Plan is intended to qualify as a Cafeteria Plan under Code §125 and is to be interpreted in a manner consistent with the requirements of that Code Section. In addition, the Health Care Flexible Spending Plan is intended to qualify as a self-insured medical expense reimbursement plan under Code §105 and is to be interpreted in a manner consistent with the requirements of that Code Section; and the Depending Care Flexible Spending Account is intended to qualify as a dependent care assistance program under Code §129 and is to be interpreted in a manner consistent with the requirements of that Code Section.

1.3 Exclusive Benefit of Participants

This Plan has been established for the exclusive benefit of the Participants and their beneficiaries.

1.4 Non-Discrimination Requirements

It is intended that this Plan meet all applicable legal requirements regarding nondiscrimination. In determining whether such requirements are met, the rules in Code §125 and the regulations thereunder, as well as any other applicable Code section or regulation, will apply.

Article 2
Definitions

2.1 Administrator

The term "Administrator" means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 Change in Status

The term "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code §125 or the regulations issued thereunder, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

(a) **Change in Marital Status.** A change in a Participant's legal marital status, including marriage, death of the Participant's spouse, divorce, legal separation or annulment.

(b) **Change in Number of Dependents.** Events that change the number of Dependents, including birth, death, adoption, and placement for adoption.

(c) **Change in Employment Status.** Any of the following events that change the employment status of a Participant or his or her spouse or Dependents: (1) a termination or commencement of employment; (2) a commencement of or return from an unpaid leave of absence; and (3) if the eligibility criteria of this Plan or other employee benefit plan of the employer of the Participant, the Participant's spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment

status with the consequence that the individual becomes or ceases to be eligible under this Plan or other employee benefit plan.

(d) **Change in Dependent Eligibility Requirements.** Any event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as a specified age, student status, or any similar circumstance.

2.3 COBRA

The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.4 Code

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

2.5 Compensation

The term "Compensation" means wages within the meaning of Code §3401(a) and all other payments of Compensation that are actually paid or made available in gross income during the Plan Year to an Employee by the Employer (in the course of the Employer's trade or business) for which the Employer is required to furnish the Employee a written statement (Form W-2) under Code §6041(d), §6051(a)(3) and §6052. Compensation must be determined without regard to any rules under Code §3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Code §3401(a)(2)). Compensation will also include amounts not currently includible in gross income by reason of Code §125, §132(f)(4), §402(e)(3), §402(h), §403(b), §401(a), or §457(b). Compensation will not include a Participant's Compensation earned prior to becoming a Participant in the Plan.

2.6 Depending Care Flexible Spending Account

The term "Depending Care Flexible Spending Account" means the Depending Care Flexible Spending Account set forth in Article 5 of the Plan.

2.7 Dependent

For purposes of this Plan, the term "Dependent" means any person who is a tax dependent of the Participant under Code §152, except that any child to whom Code §152(e) applies (regarding a child of divorced parents where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) will be treated as a Dependent of both parents. However, for purposes of the Health Care Flexible Spending Plan, the term Dependent will be determined without regard to any exceptions in Code §152(b)(1) or (b)(2) and without regard to any gross income limitations with respect to "qualifying relatives" under Code §152(d)(1)(B); and for purposes of the Depending Care Flexible Spending Account, the term Dependent means (a) a Participant's dependent as defined in Code §152(a)(1) who has not attained age 13; (b) a Participant's dependent (as defined in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or (c) the spouse of the Participant if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year. The definition of Dependent under this section is not intended and does not modify the definition of dependent for purposes of eligibility to participate in any Insurance Plan offered by the Employer.

2.8 Disability Insurance Plan

The term "Disability Insurance Plan" means a Disability Insurance Plan maintained by the Employer pursuant to Code §106 to provide coverage for Employees in the event of disability. The Employer may amend or terminate the Disability Insurance Plan in accordance with the terms of that Plan.

2.9 Effective Date

The term "Effective Date" means January 1, 2011. The original Effective Date of this amended and restated Plan was July 1, 1991.

2.10 Eligible Employee

The term "Eligible Employee" means any Employee described in Section 3.2 who is eligible to participate in one or more benefits under the terms of the Plan.

2.11 Employee

The term "Employee" means any individual who is classified by the Employer (or by a related employer that has adopted this Plan) as a common law employee and who receives W-2 compensation from the Employer (or related employer).

2.12 Employer

The term "Employer" means Livingston County and any other entity which adopts the Plan with the consent of the Employer.

2.13 Health Insurance Plan

The term "Health Insurance Plan" means any health or wellness related plan (whether insured or self-funded) maintained by the Employer, including, but not limited to, coverage under an HMO, a PPO, a traditional health insurance plan, a dental plan, a vision plan, a prescription drug plan, an accidental death and dismemberment plan, and a supplemental health insurance plan. The Employer may amend a Health Insurance Plan in accordance with the terms of that Plan.

2.14 Highly Compensated Individual

The term "Highly Compensated Individual" means an individual who is either an officer or is highly compensated. A spouse or dependent of any Highly Compensated individual is also considered to be a Highly Compensated Individual. For purposes of the foregoing, (a) the term "officer" means any individual or participant who for the preceding Plan Year (or the current Plan Year in the case of the first year of employment) was an officer, determined based on all the facts and circumstances and as described in regulations or other guidance issued under Code §125; and (b) the term "highly compensated" means any individual or participant who, for the preceding Plan Year (or the current Plan Year in the case of the first year of employment), had compensation from the employer in excess of the compensation amount specified in Code §414(q)(1)(B), as adjusted from time to time ($110,000 for 2009) and, if elected by the Employer, was also in the top-paid group of employees (determined by reference to Code §414(q)(3), generally referencing the top 20 percent of employees in terms of compensation) for such preceding Plan Year (or for the current Plan Year in the case of the first year of employment).

2.15 Highly Compensated Participant

The term "Highly Compensated Participant" means a Highly Compensated Individual who is eligible to participate in the Plan.

2.16 HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

2.17 Insurance Plan

The term Insurance Plan (or Insurance Plans) means, in the aggregate, the Health Insurance Plan, the Disability Insurance Plan and the Life Insurance Plan maintained by the Employer. The term does not include any long-term care insurance or services.

2.18 Key Employee

The term "Key Employee" means any Participant who is a Key Employee as defined in Code §416(i)(1) at any time during the preceding Plan Year, including such an employee covered by a collective bargaining agreement.

2.19 Life Insurance Plan

The term "Life Insurance Plan" means group term life insurance on the life of an Employee, but does not include such insurance if it is combined with any permanent benefit within the meaning of Treas. Reg. 1.79-0. Generally speaking, a "permanent benefit" is one whose economic value extends beyond one policy year (e.g., a paid-up or cash surrender value). The cost of any such group term life insurance in excess of $50,000 is includible in an Employee's gross income under rules prescribed by regulations under Code §125 (generally requiring use of the Table I costs as provide by the regulations under Code §79). The Employer may amend or terminate the Life Insurance Plan in accordance with the terms of that Plan.

2.20 Health Care Flexible Spending Plan

The term "Health Care Flexible Spending Plan" means the Health Care Flexible Spending Plan set forth in Article 6.

2.21 Participant

The term "Participant" means any Employee who participates in the Plan in accordance with the eligibility requirements set forth in Article 3.

2.22 Plan

The term "Plan" means the Livingston County Flexible Benefits Plan, as set forth herein, together with any and all amendments and supplements hereto.

2.23 Plan Year

The term "Plan Year" means the Plan's 12-month accounting period beginning January 1st and ending December 31st. The Plan Year will be the period of coverage for benefits provided under the Plan.

2.24 Premium Conversion Plan

The term "Premium Conversion Plan" means the provision of the Plan under which premiums are paid by Participants for certain insured benefits on a before-tax basis.

2.25 QMCSO

The term "QMCSO" means a qualified medical child support order as defined in ERISA §609(a).

Article 3
Participation

3.1 Eligibility Requirements

With regard to benefits described in Section 4.1, an Eligible Employee under Section 3.2 will be eligible to enter the Plan as a Participant in accordance with the following provisions:

(a) **Expense Reimbursement Plan.** With regard to the expense reimbursement benefit described in Section 4.1(a), an Eligible Employee under Section 3.2, who is a non-union

Employee, will be eligible to enter the Plan as a Participant on the first day of the month following the date he or she completes 1 month of employment, while an Eligible Employee under Section 3.2 who is a union Employee will be eligible to enter the Plan as a Participant on the first day of employment.

(b) **Premium Conversion Plan.** With regard to the Premium Conversion benefit described in Section 4.1(b), an Eligible Employee as described in Section 3.2 will be eligible to enter the Plan as a Participant on the same date he or she begins participation in one or more of the Insurance Plans offered under this Plan.

3.2 Eligible Employees

All Employees that are scheduled to work 30 or more hours per week are considered Eligible Employees except for individuals who serve on the Employer's board of directors who do not otherwise provide services to the Employer as an Employee.

3.3 Cessation of Participation

(a) **Events That Occasion Cessation of Participation.** A Participant will cease to be a Participant as of the earlier of (1) the date on which the Plan terminates; (2) the date of his or her termination of employment; or (3) the date on which the Employee does not participate in any benefit provided under the Plan.

(b) **Participants on Certain Leaves of Absence.** Participants who take a leave of absence either under the Family Medical Leave Act or the Uniform Services Employment or Reemployment Rights Act may elect to continue participation in the Plan during their period of leave. Participants and their Dependents eligible for coverage under the Health Care Flexible Spending Plan who are otherwise eligible to continue coverage under the Health Insurance Plan of the Employer pursuant to COBRA may continue to participate in the Health Care Flexible Spending Plan during such period of coverage. Amounts previously deferred which would otherwise continue to be deferred under this section if the Participant were still employed may be paid to the Plan as a single lump sum at the beginning of each year (or expected leave period) or on an alternative schedule as pre-determined by the Administrator.

3.4 Reinstatement of Former Participant

In general, a former Participant will become a Participant again if and when the eligibility requirements of Section 3.1 are met. If participation ended because of termination of employment and the former employee returns to work more than 30 days later but within the same Plan Year in which employment terminated, the individual will be required to wait until the first day of the Plan Year following the Plan Year in which the Employee is rehired before resuming participation, at which time he or she will be allowed to make a new benefit election. All underlying benefit options elected must allow re-entry by the Participant at that time. If participation ended because of termination of employment and the former Employee returns to employment within 30 days of termination and within the same Plan Year in which employment terminated, the Employee's prior elections will be reinstated unless there has been an intervening event that would otherwise permit a change in elections. The underlying benefit option(s) which the former Employee re-enters must allow for such re-entry by the Employee at that time.

Article 4
Optional Benefits

4.1 Benefit Options

(a) **Expense Reimbursement Benefit.** A Participant may elect under this paragraph to have his or her Compensation reduced and have the amount of such reduction applied by the Employer toward the cost of the Depending Care Flexible Spending Account established under Article 5 and the Health Care Flexible Spending Plan established under Article 6. Any such election must be made in accordance with the procedure described in Section 4.2. If a Participant makes an election under this paragraph, the amount of the reduction will be credited by the Employer to a reimbursement account established and maintained on the Participant's behalf in accordance with Article 7.

(b) **Premium Conversion Benefit.** A Participant may elect under this paragraph to have his or her Compensation reduced and have the amount of such reduction applied by the Employer to pay on a pre-tax basis the Participant's portion of the premiums under the Insurance Plans under which the Participant is covered. The election must be made in accordance with the procedure described in Section 4.2. The types and amounts of benefits available under the Insurance Plans, the requirements for participating in such plans, and the other terms and conditions of coverage and benefits are as set forth in the Insurance Plans, in other information provided by the Employer, and in the underlying contracts and policies that constitute, or are incorporated by reference in, such Insurance Plans. The benefit descriptions in the Insurance Plans, as in effect from time to time, are incorporated by reference in this Plan. The ability to pay on a pre-tax basis for the Insurance Plans is hereafter referred to as the "Premium Conversion Plan". Notwithstanding the foregoing, (1) a Participant who elects to waive participation in an Insurance Plan in which all or some portion of the premiums are paid by the Employer may elect to receive a cash payment in lieu of the Employer-paid portion of the premium. The amount of the cash payment and the specific Insurance Plans that may be waived or elected will be determined by the Employer each year and will be communicated to each eligible Employee on an annual basis.

(c) **Disability and Vacation Buy-Sell Plans.** Provided that the Employer attaches a disability and/or vacation policy to this Plan as an appendix (and provided that policy complies with applicable law) to incorporate those features, a Participant may exercise this Plan with respect to disability and/or vacation day options in accordance with the respective policy(ies) and this Plan.

4.2 Election Procedure

The benefits described in Section 4.1 (other than the Premium Conversion benefit) will become effective with respect to each Participant as of the beginning of the first pay period for which a salary reduction agreement will apply, if elected by a Participant under the procedures described in this Section. Any salary reduction agreement must apply as of a date that is before a taxable benefit (i.e., cash compensation) is currently available. Further, an election must be made before the first day of the Plan Year (or other coverage period for the benefit). Approximately 30 days prior to the commencement of each subsequent Plan Year, the Administrator will provide one or more written or electronic election forms, waiver forms and salary reduction agreements to each Participant and to each other Employee who is eligible to become a Participant at the beginning of the Plan Year. Each such person who desires one or more optional benefit coverages described in Section 4.1 (other than the Premium Conversion benefit) for the upcoming Plan Year will specify the coverage and the amount of reduction in compensation applicable to each such coverage on the appropriate election forms and will agree to a reduction in salary equal to the

total of the amounts specified for each such optional benefit. The reduction in the Participant's salary for the Plan Year for each benefit described in Section 4.1 (other than the Premium Conversion benefit) will be the amount elected by the Participant, subject to any limitations imposed on such benefits under the terms of the Plan. Each election form and salary reduction agreement must be completed and returned to the Administrator on or before such date as the Administrator will specify, which date will be no later than the beginning of the first pay period for which the Participant's salary reduction agreement applies or, if earlier, the first day of the Plan Year.

Notwithstanding the foregoing, the premium conversion benefit described in Section 4.1 will, for the initial Plan Year commencing on the Effective Date, become effective for each Employee who is participating in the Insurance Plans on that date provided the Employee has previously completed an election form to that effect. For all other Employees, participation will become effective as of the date provided for in Article 3, provided that the Employee has completed an election form to that effect prior to that date. Prior to the commencement of each subsequent Plan Year, the Administrator will make available written waiver and election forms to each eligible Employee. An election to waive or elect the benefits must be completed and returned to the Administrator on or before such date as the Administrator will specify, which date will be no later than the first day of the subsequent Plan Year. Any Employee who has waived such benefit can participate in the Plan with respect to such benefits for future Plan Years by filing an election to participate before any such future Plan Year, provided that such Insurance Plan allows the Employee to have coverage at that time. The waiver or election will be effective as of the first day of the Plan Year after the appropriate form is filed with the Administrator. The reduction in Compensation for the Plan Year for each premium payment described in Section 4.1 will equal the Participant's share of the cost of coverage under the Insurance Plans, and will be adjusted automatically in the event of a change in such cost. The maximum amount of Compensation reduction a Participant can elect cannot exceed the amount of the Participant's share of the cost of coverage under the Insurance Plans. Notwithstanding the foregoing, a Participant who elects to waive participation in an Insurance Plan in which all or some portion of the premiums are paid by the Employer will be given the option to choose a cash payment in lieu of insurance when coverage begins for the specific Insurance Plan for which the option is provided, and annually thereafter prior to the first day of each Plan Year or coverage Year. A Participant who elects cash in lieu of insurance can participate in the Plan for future Plan Years by filing a written election to participate before such future Plan Year, provided that if the individual was not previously covered by the Insurance Plan, the desired Insurance Plan must allow for coverage at that time.

4.3 Failure to Elect

An Employee who fails to return a completed election form to the Administrator relating to the optional benefits described in Section 4.1 (other than the Premium Conversion benefit) on or before the specified due date for the initial Plan Year of the Plan or for the Plan Year in which he or she becomes a Participant will be deemed to have elected to receive his or her full Compensation in cash. For subsequent Plan Years, a Participant who fails to return a completed election to the Administrator relating to such optional benefits on or before the specified due date for any Plan Year will be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during the preceding Plan Year.

Notwithstanding the foregoing, an Employee who fails to return a completed election form to the Administrator relating to the Premium Conversion benefit described in Section 4.1 on or before the specified due date for the Plan Year in which he or she becomes a Participant will be deemed to have elected not to participate in the Premium Conversion Plan. For subsequent Plan Years, a Participant who fails to return a completed waiver or election form, as applicable, to the Administrator related to such benefits on or before the specified due date for any Plan Year will be deemed to be have elected not to participate in the Plan for such Plan year regardless of the

election in effect for the prior Plan Year (except for the Premium Conversion benefit in which case the prior election will control until changed). With respect to an election to waive coverage under an Insurance Plan as permitted under Section 4.1, an Employee who fails to return a completed election form to the Administrator on or before the specified due date for the applicable Plan Year will be deemed to have elected not to receive cash in lieu of the covered benefit.

An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the entry date in Section 3.1 which is coincident with or next follows the date the eligibility requirements are met. The election will be made by submitting an election form as specified by the Administrator in accordance with Section 4.2. An Employee who does not elect to participate in the Plan when such Employee is first eligible to participate in the Plan may not participate in the Plan until the beginning of the next Plan Year.

4.4 Changes by Administrator

The Plan will not discriminate in favor of Highly Compensated Individuals as to eligibility to participate for that Plan Year, nor in favor of Highly Compensated Participants as to contributions and benefits for a Plan Year. Further, the nontaxable benefits provided to Key Employees will not exceed 25% of the aggregate nontaxable benefits provided for all Employees under the Plan. If the Administrator determines before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator will take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Participants or Key Employees with or without the consent of such Employees. Further, in interpreting and applying the nondiscrimination provisions of this paragraph, the regulations and guidance under Code §125 is hereby incorporated by reference, including but not limited to any safe harbor provisions and testing methodologies.

4.5 Irrevocability of Election by the Participant

(a) **Elections Are Irrevocable.** Elections made or deemed to be made under the Plan will be irrevocable during the Plan Year, subject to a Change in Status or other event described in Code §125 and the Plan that allows an election change. If there is a Change in Status, a Participant may revoke a benefit election for the balance of a Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a Change in Status. Any new election permitted under the Plan will be effective at such time as the Administrator prescribes, but not earlier than the first pay period beginning after an election form is completed and returned to the Administrator.

(b) **Forfeiture of Unapplied Salary Reduction Amounts.** The amount of any salary reduction amounts not applied against medical and dependent care expenses will be forfeited by the Participant and used as set forth in Section 4.5(c).

(c) **Continued Reduction of Compensation and Forfeiture of Unapplied Amounts.** If a Participant ceases or changes the extent of his or her participation in the Insurance Plans of the Employer for any reason other than a Change in Status or other event that permits an election change, the Participant's Compensation will continue to be reduced by an amount equal to that portion of the premiums previously payable during such Plan Year for benefits under the Insurance Plans. The amount of any reduction not applied towards payment of premiums will be forfeited by the Participant and used in any manner allowed by law, including but not limited to, defraying the reasonable expense of administering the Plan.

The amount of Compensation reduction will automatically be adjusted for substantial increases or decreases of coverage.

4.6 Events Permitting Exception to Irrevocability Rule

(a) **Change in Status.** A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if the change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or under a plan of the employer of the Participant's spouse or Dependent (the "general consistency requirement"). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the employer of the Participant's spouse or Dependent includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a spouse and/or Dependents) who may benefit from the coverage. Election changes may not be made to reduce Health Care Flexible Spending Plan coverage during a Plan Year; however, election changes may be made to cancel Health Care Flexible Spending Plan coverage completely due to the death of a spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health Care Flexible Spending Plan coverage; or a Dependent's ceasing to satisfy eligibility for Health Care Flexible Spending Plan coverage due to attaining a certain age.

(1) **Loss of Spouse or Dependent Eligibility - Special COBRA rules.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a spouse, the death of a Participant's spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (A) the spouse involved in the divorce, annulment or legal separation; (B) the deceased spouse or Dependent; or (C) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances will fail to correspond with that Change in Status. If the Participant or his or her spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under state law, under the Employer's plan, the Participant may increase an election to pay for such coverage. This rule does not apply to a Participant's spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation.

(2) **Gain of Coverage Eligibility under another Employer's Plan.** For a Change in Status in which a Participant or his or her spouse or Dependent gains eligibility for coverage under a benefit plan of the employer of the Participant's spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that he or she has obtained or will obtain coverage under the spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.

(3) **Special Consistency Rule for Depending Care Flexible Spending Account Benefits.** With respect to Depending Care Flexible Spending Account benefits, a Participant may change or terminate his or her election upon a Change in Status if (A) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (B) the election change is on account of and corresponds with a Change in Status that affects

eligibility of Dependent Care Reimbursement Expenses for the tax exclusion under Code §129.

(4) **Special Consistency Rule for Life Insurance.** For any Change in Status, a Participant may elect either to increase or decrease his or her election for life insurance benefits, as applicable.

(b) **HIPAA Special Enrollment Rights.** If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan as required under Code §9801(f) or under the provisions of HIPAA, a Participant may revoke a prior election for group health plan coverage and make a new election if the election change corresponds with the HIPAA special enrollment right under the group health plan. As required by HIPAA, a special enrollment right will arise under the following circumstances:

(1) **No Enrollment in Group Health Plan.** If a Participant or his or her spouse or Dependent declines to enroll in group health plan coverage because he or she has other coverage and eligibility for such coverage is subsequently lost (as interpreted under HIPAA), or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions were terminated; or

(2) **Acquisition of New Dependent.** If a new Dependent is acquired as a result of marriage, birth, adoption or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new spouse or Dependent child will be considered to be consistent with the HIPAA special enrollment right, provided that the group health plan allows such previously eligible Dependent to enroll at that time. An election change on account of the HIPAA special enrollment right attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective up to 30 days retroactively.

(c) **Judgments, Decrees and Orders.** This paragraph applies to Premium Conversion Plans that provide accident or health coverage, and to Medical Care Reimbursement benefits, but not to Dependent Care Reimbursement benefits. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMSCO) requires accident or health coverage (including an election for Medical Care Reimbursement benefits) for a Participant's Dependent child, a Participant may (1) change an election to provide coverage for the Dependent child provided the Order requires the Participant to provide coverage; or (2) change an election to revoke coverage for the Dependent child if the Order requires that another individual provide coverage under that individual's plan, and such coverage is actually provided.

(d) **Medicare and Medicaid.** This paragraph applies to Premium Conversion Plan Benefits that provide accident or health coverage, and to Medical Care Reimbursement benefits, but not to Dependent Care Reimbursement benefits. If a Participant or his or her spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under §1928 of the Social Security Act for distribution of pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Medical Care Reimbursement coverage may be canceled but not reduced. Further, if a Participant or his or her spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or

health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Medical Care Reimbursement coverage may commence or increase.

(e) **Changes in Cost.** This paragraph applies to Premium Conversion Plan benefits and to Dependent Care Reimbursement benefits, but not to Medical Care Reimbursement benefits. For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals, e.g. family to family or single to single. For purposes of this definition, (1) Health Care Flexible Spending Plan coverage is not similar coverage with respect to an accident or health plan that is not a Health Care Flexible Spending Plan; (2) a health maintenance organization and a preferred provider organization are considered similar coverage; and (3) coverage by another employer, such as the employer of the Participant's spouse or Dependent, is treated as similar coverage hereunder.

(1) **Increase or Decrease for Insignificant Cost Changes.** The Administrator, on a reasonable and consistent basis, will automatically increase or decrease an affected Participant's election contributions to reflect an insignificant increase or decrease to his or her required costs for benefits under the Plan. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine if an increase or decrease is insignificant, based upon all the surrounding facts and circumstances, including, but not limited to the dollar amount or percentage of cost change. All changes to a Participant's election contributions will take place prospectively.

(2) **Significant Cost Increases.** If the Administrator determines that the cost of a Participant's accident, health, life or disability plan significantly increases during the Plan Year, the Participant may (A) make a corresponding prospective increase in his or her elective coverage; (B) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another accident or health plan that provides similar coverage; or (C) drop coverage prospectively if there is no other accident or health plan available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) **Significant Cost Decreases.** If the Administrator determines that the cost of any accident, health, life or disability plan significantly decreases during the Plan Year, the Administrator may permit the following election changes: (A) Participants who are enrolled in the plan whose costs have decreased may make a corresponding election change by decreasing their salary reduction amount; (B) Participants who are enrolled in an accident, health, life or disability plan other than the accident, health, life or disability plan that has a decrease in cost may change their elections on a prospective basis to elect the accident, health, life or disability plan that has decreased in cost; and (C) Employees who are otherwise eligible under Article 3 may elect the accident, health, life or disability insurance plan that has decreased in cost on a prospective basis, subject to the terms and limitations of the accident, health, life or disability plan. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) **Limitation on Change in Cost Provisions for Dependent Care Reimbursement Benefits.** The above "Change in Cost" provisions apply to Dependent Care Reimbursement benefits only if the cost change is imposed by a Dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §152(d)(2)(A) through (G), incorporating the rules of Code §152(f)(1) and (f)(4).

(f) **Change in Coverage.** This paragraph applies to Premium Conversion Plan benefits and to Dependent Care Reimbursement benefits but not to Medical Care Reimbursement benefits. The definition of "similar coverage" as set forth in paragraph (e) above also applies to the provisions of this paragraph (f).

(1) **Significant Curtailment.** If coverage is "significantly curtailed" as defined below, Participants may elect coverage under another accident, health, life or disability plan that provides similar coverage. In addition, if the coverage curtailment results in a "loss of coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide if a curtailment is significant and whether a "loss of coverage" has occurred in accordance with prevailing IRS guidance.

(A) **Significant Curtailment Without a Loss of Coverage.** If the Administrator determines that a Participant's coverage under an accident or health plan under this Plan, or the Participant's spouse's or Dependent's coverage under his or her employer's plan is significantly curtailed without a "loss of coverage" (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit) during a Plan Year, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another accident, health, life or disability plan that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) **Significant Curtailment With a Loss of Coverage.** If the Administrator determines that a Participant's coverage under an accident or health plan under this Plan, or the Participant's spouse's or Dependent's coverage under his or her employer's plan is significantly curtailed, and such curtailment results in a Loss of Coverage, the Participant may revoke the election for the affected coverage and may elect coverage under another accident, health, life or disability plan that provides similar coverage, or drop coverage if no other accident, health, life or disability plan providing similar coverage is offered by the Employer.

(C) **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" is a complete loss of coverage, including (i) the elimination of an accident, health, life, or disability plan; (ii) a health maintenance organization ceasing to be available where the Participant or his or her spouse or Dependent resides; or (iii) a Participant or his or her spouse or Dependent losing all coverage under an accident, health, life or disability plan by reason of an overall lifetime or annual limitation. In addition, the Administrator, in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage: (iv) substantial decrease in the medical care providers available under an accident or health plan, such as a major medical hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in an HMO or preferred provider network; (v) a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant, the Participant's spouse or the Participant's Dependent is currently in a course of treatment; or (vi) any other similar fundamental loss of coverage.

(2) **Addition or Significant Improvement of an Accident, Health, Life or Disability Plan Option.** If during the Plan Year the Plan adds a new accident, health, life or disability plan option or significantly improves an existing option, the Administrator may permit the following election changes: (A) Participants enrolled in an option other than the newly-added or significantly improved option may change their election on a prospective basis to elect the newly-added or significantly improved option; and (B) Employees otherwise eligible under Article 3 may elect the newly-added or significantly improved option on a prospective basis, subject to the terms and limitations of the option itself. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of or a significant improvement in an option in accordance with prevailing IRS guidance.

(3) **Loss of Coverage Under Other Group Health Coverage.** A Participant can prospectively change an election to add group health coverage for the Participant or his or her spouse or Dependent if such individual loses coverage under any group health coverage sponsored by a governmental or educational institution, including but not limited to the following: (A) a state children's health insurance plan 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; a state health benefits risk pool; or (C) a foreign government group health plan.

(4) **Change in Coverage Under Another Plan.** A Participant can make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer) if (A) the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under applicable regulations and guidance under Code §125, or (B) the Plan permits Participants to make an election for a Plan Year that is different from the plan year in the other cafeteria plan or qualified benefits plan. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide if a requested change complies with applicable guidance under Code §125.

(5) **Dependent Care Reimbursement Coverage Changes.** A Participant may prospectively change an election that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (A) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (B) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

4.7 Reimbursable Expenses on Termination of Participation

The Participant (or the Participant's estate) will be entitled to reimbursement under the Health Care Flexible Spending Plan and the Depending Care Flexible Spending Account only for expenses incurred within the same Plan Year and while the Participant is a Participant in the applicable expense reimbursement option. In order to receive such reimbursement, the terminated Participant (or the Participant's estate) must apply for such reimbursement on or before the earlier of (a) the 90th day following the date participation in the Plan is terminated, and (b) the 90th day after the close of the Plan Year or, if the grace period applies to the terminated Participant as described in Section 7.5, then by the end of the filing period that applies to grace period claims. Expenses eligible for reimbursement will be paid within 90 days following the date application for reimbursement is properly made.

4.8 Plan Contributions

Contributions for each Plan Year will consist of the aggregate amounts applied to the payment of benefits under Article 5, the payment of benefits under Article 6, and amounts used to pay premiums under Section 4.1(b).

4.9 Automatic Termination of Election

Plan elections made or deemed to be made will automatically terminate on the date a Participant ceases to be a Participant in the Plan, but coverage or benefits under the Insurance Plans may continue if and to the extent provided by such Plan. Any Participant who terminates employment and is rehired may resume participation as provided in Section 3.4 However, notwithstanding any provision in the Plan to the contrary, to the extent required by COBRA, a Participant and his or her spouse and Dependents whose coverage terminates under the Health Care Flexible Spending Plan because of a COBRA qualifying event will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Care Flexible Spending Plan the day before the qualifying event for the period prescribed by COBRA, subject to all conditions and limitations under COBRA, but not beyond the current Plan Year. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Care Reimbursement account balance at the time of the COBRA qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified that they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the Medical Expense Reimbursement Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

Article 5
Depending Care Flexible Spending Account

5.1 Depending Care Flexible Spending Account Benefits

This Depending Care Flexible Spending Account is established pursuant to Code §129 as a dependent care assistance program. An Eligible Employee can elect to participate by agreeing to reduce his or her Compensation on a pre-tax basis and have that amount contributed to an account that will be used to reimburse the Participant for expenses for qualifying employment-related dependent care services. The maximum amount of reimbursement from the Participant's account will be the amount currently available in the account, properly reduced as of any particular time for prior reimbursements, subject to any limitations required by law as provided below in Section 5.2.

5.2 Claim for Reimbursement and Payment of Benefits

A Participant who has elected to receive Dependent Care Reimbursements for a Plan Year may apply for reimbursement of qualifying expenses properly incurred during the Plan Year. A dependent care expense is incurred at the time the services are furnished, not when the Participant is formally billed for, is charged for, or pays for the expense. After a Participant has made a proper claim for reimbursement in accordance with Article 7, the Employer will apply any reduction in Compensation elected by the Participant then standing in the Participant's account (which will be adjusted for prior reimbursements) for the payment of qualifying benefits under the Depending Care Flexible Spending Account.

Qualifying benefits include expenses incurred for the cost of dependent care assistance during the period to which a Participant's election applies which, if paid by the Participant, would be considered an employment-related expense under Code §21(b)(2). The Administrator may also elect to make payments for the cost of any such dependent care assistance by making payments directly to the service provider. The dependent care must be provided to or on behalf of the Participant during the period for which the Participant is covered by this program. Expenses incurred before the later of the program's effective date and the date the Employee is enrolled in the program are not incurred during the period when the Employee is covered by the program.

No reimbursement will be made to the extent that, when taken with other such reimbursements for the Participant's taxable year, it exceeds the lesser of (a) the amounts remaining in the Participant's Dependent Care Reimbursement Account; (b) in the case of a Participant who is not married as of the end of his or her taxable year, that Participant's earned income; (c) in the case of a Participant who is married as of the end of his or her taxable year, the lesser of (i) the Participant's earned income for such taxable year, or (ii) the spouse's earned income for such taxable year; or (d) the lesser of $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules set forth in Code §21(e)(3) and Code §21(e)(4)) or other applicable limit established by law. For purposes of the preceding sentence, "earned income" will have the meaning provided for in Code §129(e)(2); provided that the provisions of Code §21(d)(2) will apply in determining the earned income of a spouse who is a student or is incapable of caring for himself or herself. No reimbursement will be made under this Article 5 for amounts paid or payable to an individual related to the Participant within the meaning of Code §129(c).

5.3 Limitations

No reimbursement will be made for expenses incurred during any Plan Year from a reduction in Compensation made during any other Plan Year, unless the 2 ½ month grace period (as described in Section 7.5) applies to the Participant .

5.4 Construction

The Depending Care Flexible Spending Account established in this Article 5 is intended to meet the requirements of Code §129 and the regulations thereunder, and will be interpreted and administered in accordance therewith.

5.5 Reports to Employees

Pursuant to Code §129(d)(7), prior to each February 1st the Administrator will provide each Participant with a statement of the amounts paid to such Participant during the previous calendar year under the Depending Care Flexible Spending Account.

Article 6
Health Care Flexible Spending Plan

6.1 Medical Reimbursement Plan Benefits

This Health Care Flexible Spending Plan is established pursuant to Code §105 as an accident and health plan. An Eligible Employee can elect to participate by agreeing to reduce his or her Compensation on a pre-tax basis and have that amount contributed to an account that will be used to reimburse the Participant for Qualifying Medical Care Expenses. The maximum amount of reimbursement from the Participant's account will be available at all times during the Plan Year, properly reduced as of any particular time for prior reimbursements, and will not relate to the amount that has been contributed to the account at any particular time prior to the end of the Plan Year. Similarly, the payment schedule for contributions to the Participant's account will not be based on the rate or amount of covered claims incurred during the Plan Year. The Participant's

pre-tax salary reduction payments will not be accelerated based on his or her incurred claims and reimbursements. Reimbursements under the Plan will be paid at least monthly.

6.2 Claims for Reimbursement

A Participant who has elected to receive Medical Care Reimbursements for a Plan Year may apply for reimbursement of Qualifying Medical Care Expenses incurred by the Participant during the Plan Year (or during the applicable grace period as described in Section 7.4, if the grace period applies to the Participant) by submitting a proper request for reimbursement in accordance with Article 7. A Qualifying Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the medical care. As to orthodontia services, the Plan permits the reimbursement of expenses before the services are actually provided, but only if the Participant has actually made the payments in advance of the services. In this case, the orthodontia services are deemed to be incurred when the Participant makes the advance payment.

6.3 Qualifying Medical Care Expense

As used in this Article, the term "Qualifying Medical Care Expense" means an expense incurred by a Participant, or by his or her spouse or Dependent, for medical care as defined in Code §213 as allowed under Code §105 and the regulations thereunder (including without limitation amounts paid for hospital bills, doctor and dental bills, and payments for prescription drugs), but only to the extent the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under the Plan). Notwithstanding the foregoing, the term Qualifying Medical Care Expense does not include expenses incurred (a) for other health coverage (such as premiums paid under a plan maintained by the employer of the Participant's spouse or Dependents), and (b) for "qualified long-term care services" as defined in Code §7702B(c), but does include insulin and other minor items provided on Choices Guide appendix to this Plan.

6.4 Reimbursement or Payment of Expenses

The Employer will reimburse a Participant from his or her Reimbursement Account for properly incurred Qualifying Medical Care Expenses for which the Participant submits a claim for reimbursement in accordance with Article 7. The Employer may, at its option, pay any such Qualifying Medical Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant.

6.5 Qualified Medical Child Support Orders (QMCSO)

This Health Care Flexible Spending Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

6.6 Limitation on Benefits

Notwithstanding any provision in this Article 6 to the contrary, no more than $5,000 (or a lesser amount if established by law) can be allocated to a Participant's Medical Care Reimbursement Account.

Article 7
Reimbursement Accounts

7.1 Establishment of Accounts

The Employer will establish and maintain a reimbursement account (or accounts) for each Plan Year with respect to each Participant who has elected to receive reimbursement of Dependent care expenses under Article 5 and Qualifying Medical Care Expenses under Article 6 which are incurred during the Plan Year or during the grace period as described in Section 7.5 below.

7.2 Crediting of Accounts

There will be credited to a Participant's accounts for each Plan Year, as of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's election and Compensation Reduction Agreement under the Plan. All amounts credited to each such account will be the property of the Employer until paid out or otherwise administered pursuant to this Article 7. Amounts credited to each such account will be used to provide reimbursement to the Participant only for the type of expense allowed by the particular account and will not provide other taxable or nontaxable benefits.

7.3 Debiting of Accounts

A Participant's reimbursement account (or accounts) will be debited from time to time for any payment made to or for the benefit of the Participant under this Article 7 for Dependent care expenses under Article 5 and for Qualifying Medical Care Expenses under Article 6 which are incurred during the Plan Year (or during the grace period as described in Section 7.5 below). Amounts debited to each such account will be treated as payments of the earliest amounts credited to the account, and not yet paid, under a "first-in/first-out" approach.

7.4 Claims for Reimbursement

In order to receive reimbursement of a benefit, the Participant must submit a claim for reimbursement in such form or manner as the Employer may prescribe. Such claim must be submitted no later than 90 day after the close of the Plan Year. See Section 4.7 for the reimbursement deadline for submitting a claim upon termination of participation. The claim must be properly substantiated as an eligible expense, in a manner approved by the Administrator, by setting forth information from a third-party that is independent of the Participant and his or her spouse and Dependents. The independent third-party must provide information describing the service or product, the date of the service or sale, and the amount. The Administrator may prescribe additional requirements to properly substantiate a claim for reimbursement under the applicable reimbursement plan so that the information submitted shows an expense that is properly payable in accordance with the Code section that governs the reimbursement plan. Self-substantiation of an expense by a Participant is not permitted. An expense will not be reimbursed before the expense has been properly incurred or before the expense is properly substantiated. An expense is not properly incurred if it is prior to the effective date of the reimbursement arrangement or prior to the date the Participant is enrolled in the reimbursement arrangement.

With respect to the Health Care Flexible Spending Plan, if the Administrator is provided with information from an independent third-party (such as an "explanation of benefits"(EOB) from an insurance program) indicating the date of the medical care and the employee's responsibility for payment for that care (i.e., coinsurance payments and amounts below the plan's deductible), and the Participant certifies that any expense paid through the Health Care Flexible Spending Plan has not been reimbursed and that the Participant will not seek reimbursement from any other plan covering health benefits, the claim is fully substantiated without the need for submission of a receipt by the Participant or further review.

7.5 Forfeiture of Accounts - Use or Lose Rule

The amount credited to a Participant's accounts for any Plan Year will be used only to reimburse the Participant for Dependent care expenses under Article 5 and for Qualifying Medical Care Expenses under Article 6, each of which account will be used only to reimburse qualifying expenses under the account. For example, a Dependent care account will not reimburse for Qualifying Medical Care Expenses, and vice versa. To be properly reimbursable, such expense must be incurred during such Plan Year, and the Participant must apply for reimbursement on or before the 90th day following the close of the Plan Year or 90 days after termination of employment, if earlier. If any balance remains in the Participant's accounts for a Plan Year after

all reimbursements hereunder, such balance will not be carried over to reimburse the Participant for Dependent care expenses and for Qualifying Medical Care Expenses incurred during a subsequent Plan Year, and will not be available to the Participant in any other form or manner, and the Participant will forfeit all rights with respect to such balance. Forfeitures with respect to a Plan Year may be retained by the Employer as the law permits or used in one or more of the following ways in the discretion of the Employer: (a) to defray expenses incurred by the Employer to administer the Plan; (b) to reduce required salary reduction amounts for the immediately following Plan Year, on a reasonable and uniform basis as described in regulations and guidance under Code §125; or (c) returned to the Employees on a reasonable and uniform basis, as described in regulations and guidance under Code §125. Such balance may continue to be used during the 2½ month period following the close of the Plan Year (the "grace period") to reimburse the Participant for Dependent care expenses and for Qualifying Medical Care Expenses incurred during the grace period as if the expenses had been incurred in the immediately preceding Plan Year for Dependent care expenses and for Qualifying Medical Care Expenses. Each such account will reimburse only for the expenses eligible to be paid from that account. For example, unused amounts in the Dependent Care Reimbursement account may not be used to pay or reimburse medical expenses incurred during the grace period, and vice versa. The Administrator may defer allocation of grace period expenses until after the end of the grace period, at which time expenses submitted for claims incurred during the grace period will be applied to unused contributions or benefits from the immediately preceding year or applied to current year contributions and benefits once the prior year amounts are exhausted. Any balance remaining from the prior Plan Year which is not used during the grace period will not be available to the Participant in any other form or manner and may not be carried forward to any subsequent period. The Participant will forfeit all rights with respect to such balance. In addition, during the grace period, the Plan may not permit unused benefits or contributions to be cashed-out or converted to any other taxable or nontaxable benefit. Forfeitures with respect to a Plan Year may be retained by the Employer as the law permits or used in one or more of the following ways in the discretion of the Employer: (a) to defray expenses incurred by the Employer to administer the Plan; (b) to reduce required salary reduction amounts for the immediately following Plan Year, on a reasonable and uniform basis as described in regulations and guidance under Code §125; or (c) returned to the Employees on a reasonable and uniform basis, as described in regulations and guidance under Code §125.

7.6 No Trust Created

The Employer will set up a reserve for the amount credited to each Participant's account, but no assets of the Employer will be specifically set aside for the payment of contributions, withdrawals or distributions hereunder, and references to "credits" and other related terms herein will refer only to the setting up of such a reserve. The Plan does not create a trust in favor of a Participant or any person claiming on a Participant's behalf, and the obligation of the Employer is solely a contractual obligation to make payments due hereunder. In this regard, the balance of any account will be considered a liability of the Employer, and a Participant's right thereto will be the same as that of any unsecured general creditor of the Employer. Neither the Participant nor any other person will acquire any right, title or interest in or to any contribution under the Plan or balance in any account other than the right to the actual payment of contributions, withdrawals and distributions in accordance with the terms of the Plan.

Article 8
Plan Administration

8.1 Administrator

The administration of the Plan will be under the supervision of the Administrator. It will be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms,

for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have the full power and discretion to administer the Plan in all of its details, subject to applicable requirements of law, and its decisions will be final and binding (and receive the most deferential treatment) to the fullest extent of the law, including case law. For this purpose, the Administrator's discretionary powers will include but not be limited to the following, in addition to all other powers provided by this Plan: (a) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan; (b) to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming Plan benefits; (c) to decide all questions concerning the Plan and the eligibility of any person to participate therein; (d) to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and (e) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of those responsibilities, any such allocation, delegation or designation to be in writing.

8.2 Examination of Records

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

8.3 Reliance on Tables, Etc.

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

8.4 Claims and Review Procedures

Claims for benefits under the Insurance Plans including the Health Care Flexible Spending Plan and the Depending Care Flexible Spending Account will be reviewed in accordance with the procedures contained in the policies for such Plans and/or in the applicable summary plan descriptions.

8.5 Nondiscriminatory Exercise of Authority

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

8.6 Indemnification of Administrator

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

Article 9
Amendment and Termination

9.1 Amendment or Termination of Cafeteria Plan

The Plan may at any time be amended or terminated by a written instrument signed by Livingston County. Upon termination of the Plan, all elections and reductions in Compensation under the Plan will terminate. Any amounts remaining in a Participant's Reimbursement Account will be reimbursed in accordance with Section 4.7. Any reduction in a Participant's Compensation made prior to termination of the Plan, for purposes of paying that portion of the premiums payable by a

Participant for benefits under the Insurance Plans that were not applied to such payment, will be applied to the next premium payable by the Participant.

9.2 Amendment or Termination of Insurance Plans

Nothing contained in the Plan will limit the right of Livingston County, without notice to or consent from any Employee, to amend or terminate the Insurance Plans.

Article 10
Miscellaneous Provisions

10.1 Information to be Furnished

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

10.2 Limitation of Rights

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

10.3 No Guarantee of Tax Consequences; Indemnification of Employer

While the Employer intends that the amounts applied to the payment of one or more of the optional benefits described in Section 4.1 will be excludable from the Participant's gross income for federal income tax purposes, neither the Employer nor the Administrator makes any commitment or guarantee that these amounts will be so excludable, or that any other federal, state, or local tax treatment will apply. It is the Participant's obligation to notify the Employer if the Participant has any reason to believe that any payment is not excludable from his or her gross income. If any before-tax payment made on behalf of a Participant for one or more of the optional benefits described in Section 4.1 is disallowed by any federal, state, or local taxing authority, the Participant must indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local taxes that the Participant would have owed if such payment 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.

10.4 Governing Law

Except to the extent superceded by Federal law, this Plan will be construed, administered and enforced according to the laws of the State of Michigan.

10.5 Use Of Electronic Media

Notwithstanding anything contained herein to the contrary, in any provisions of this Plan where there is a requirement that a Participant provide a written notice, election or claim for benefit, such requirement may be satisfied by electronic media provided such Participant meets all requirements regarding electronic media as set forth by the Administrator.

10.6 Application Of Plan Surplus

In no event will any amounts forfeited by a Participant because of failure to submit a claim for reimbursement within the time frame set forth herein be used to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other benefit available under the Plan. Nor will any amounts forfeited by a Participant be made available to such Participant in any other form or manner except as permitted by Treasury regulations. Forfeited amounts will be used to defray administrative costs and experience losses incurred by the Plan.

10.7 HIPAA Requirements

The terms of this Section apply if the HIPAA administrative simplification rules apply to the Health Care Flexible Spending Plan (the "Plan" for purposes of this Section). In that event, the Plan will protect the confidentiality and privacy of individually identifiable health information and the security and integrity of such information that is in electronic form, and the Plan and those administering it will use and disclose health information only as allowed by Federal law and in accordance with a HIPAA Privacy Policy established by the Administrator, the terms of which are incorporated herein by reference. The Plan may disclose summary health information (as defined by HIPAA) to the Employer, if the Employer requests that information for the purpose of modifying, amending, or terminating the Plan. The Employer agrees, as required by 45 CFR 164.504(f)(ii), that with respect to any protected health information (as defined by HIPAA, other than enrollment and disenrollment information and summary health information) disclosed to the Employer by the Plan, the Employer will: (a) not use or further disclose the 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 Employer with respect to such information; (c) not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer; (d) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware; (e) make available protected health information in accordance with 45 CFR §164.524, having to do with the individual's right to access; (f) make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526; (g) make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528; (h) 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 HIPAA's privacy rules; (i) if feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (j) ensure that there is adequate separation between the Plan and the Employer, as required in 45 CFR §504(f)(2)(iii) is satisfied. Adequate separation will be accomplished by: (a) allowing access to protected health information only by employees who work in the benefits or human resources areas of the Employer, and to its appropriate management, including those with financial oversight, (b) allowing such described employees to have access to and use of such information only for the Plan administration functions that the Employer performs for the Plan, and (c) subjecting such employees to disciplinary action by the Employer for non-compliance with HIPAA's privacy rules. The Plan will disclose protected health information to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the above provisions.

10.8 COBRA Requirements

If COBRA applies to this Plan, the Plan will provide all notices required under Department of Labor Regulations §1.2590.606-1 through §1.2590.606-4.

This Plan has been executed by the Employer as of this _____day of _____, 20____.

Livingston County

By _____ Title _____

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