PLACER COUNTY

Amended and Restated
CAFETERIA PLAN
for the
PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM

Original Effective Date: July 1, 1991

This Document is effective January 1, 2008.

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PREAMBLE

Effective as of the date set forth below, **PLACER COUNTY** established a cafeteria plan for the **PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM** (the "Plan" or "Cafeteria Plan") for purposes of providing Eligible Employees with the opportunity to choose from among the Benefit Package Options available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

PLACER COUNTY

Amended and Restated
CAFETERIA PLAN
for the
PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM

ARTICLE I
DEFINITIONS

1.01 "Affiliated Employer" means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

1.02 "After-Tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

1.03 "Anniversary Date" means the first day of any Plan Year.

1.04 "Benefits Administrator" means Fringe Benefits Management Company (FBMC), which has agreed to perform certain services on behalf of the Plan Administrator as set forth in the FBMC plan services agreement.

1.05 "Benefit Package Option(s)" means those Qualified Benefits available to a Participant under this Plan as set forth in the enrollment materials for the applicable Plan Year (the "enrollment materials") or Summary Plan Description, as amended and/or restated from time to time.

1.06 "Board of Supervisors" means the Board of Supervisors or other governing body of the Employer (the "Board"). The Board of Supervisors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.07 "Change in Status" means any of the events described in the Summary Plan Description or enrollment materials, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the Summary Plan Description or enrollment materials for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.08 "Code" means the Internal Revenue Code of 1986, as amended.

1.09 "Compensation" means the cash wages or salary paid to an Employee by the Employer.

1.10 "Dependent" means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a); however, that in the case of a health benefits, a Dependent shall be defined as set forth in Code Section 105(b) and for purposes of the Dependent Care FSA, a Dependent shall be defined as set forth in Code Section 21(b)(1). For purposes of the Dependent Care FSA Plan, a Dependent shall also be defined as in Code Section 21(e)(5) (i.e., dependent of the parent with custody for the greatest portion of the year).

1.11 "Effective Date" of the Plan means July 1, 1991 for the Placer County Management and Confidential Team. This is the date the Plan was established. It will not necessarily coincide with the date of this document as set forth in the title page.

1.12 "Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

1.13 "Employer" means **Placer County**. Any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Notwithstanding the previous sentence when the Plan provides that the Employer has a certain power (e.g., the appointment of a Benefits Administrator, entering into a contract with a third-party insurer, or amendment or termination of the plan) the term "Employer" shall only mean Placer County. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in the Summary Plan Description.

1.14 "Highly Compensated Individual" means an individual defined under Code Section 125(e), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.15 "Key Employee" means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.16 "Non-Elective Contribution(s)" means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of Employer Contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and non-discriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the Summary Plan Description or enrollment materials, the Employer may make Non-Elective Contributions available to Participants and allow Participants to allocate the Non-Elective Contributions among the various Benefit Package Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment materials. In no event will any Non-Elective Contribution be disbursed to a Participant in the form of additional taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment materials.

To the extent set forth in the Summary Plan Description or enrollment materials, if an Employee declines enrollment for himself under any of the Employer's Component Health Plans, the Employer's Non-Elective Contribution designated for such coverage will automatically be placed into a 401(k) for said Employee.

1.17 "Participant" means an Employee who becomes a Participant pursuant to Article II.

1.18 "Plan" means this Cafeteria Plan, as set forth herein.

1.19 "Plan Administrator" means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.20 "Plan Year" shall be the period of coverage set forth in the Summary Plan Description.

1.21 "Pre-Tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.22 "Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."

1.23 "Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Package Options with Pre-Tax or After-Tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.24 "Spouse" means an individual who is legally married to a Participant (and who is treated as a spouse under the Code).

1.25 "Student" means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

1.26 "Summary Plan Description" or "SPD" means the SPD for the Placer County *Amended and Restated* Cafeteria Plan for the Placer County Management and Confidential Team and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Attachment I, as amended from time to time. The term SPD is utilized merely for convenience. The SPD and Appendices are incorporated hereto by reference.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD or enrollment materials shall be eligible to participate in this Plan as of the Eligibility Date set forth in the SPD or enrollment materials. Eligibility to participate in this Plan means only that the Eligible Employee is entitled to contribute his share of the cost of applicable Benefit Package Options for which he is eligible with Pre-Tax Contributions. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Package Options and the terms of eligibility and participation for the Benefit Package Option(s) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Package Options.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD and enrollment materials.

2.03 Qualifying Leave Under Family Medical Leave Act. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Package Options that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD or enrollment materials and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.04 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Package Options chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD or enrollment materials and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Package Options chosen by the Participant, the election change rules in Section 3.04 will apply.

ARTICLE III
PREMIUM ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-Tax Contributions or After-Tax Contributions (to the extent set forth in the enrollment materials) to fund any Benefit Package Option available under the Plan, provided that only Qualified Benefits may be funded with Pre-Tax Contributions. The Employer may, but is not required to, allocate Non-Elective Contributions to one or more Benefit Package Options offered under the Plan and to the extent set forth in the SPD or enrollment materials, may allow the Participants to allocate his allotted share of Non-Elective Contributions among the various Benefit Package Options in a manner set forth in the SPD or enrollment materials.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period.** An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment materials. Participation will commence under this Plan as set forth in the SPD or enrollment materials. Coverage under the component Benefit Package Options will be effective in accordance with the governing provisions of such Benefit Package Options.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial

election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right; such period of time shall be known as the Annual Election Period. The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment materials. An election is made during the Annual Election Period in the manner set forth in the SPD or enrollment materials. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD or enrollment materials.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-Tax Contribution amount or, where applicable, to the Participant's elected allocation of Non-Elective Contributions except under the circumstances set forth in the SPD or enrollment materials and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility, and changes pursuant to the Family Medical Leave Act. Except as provided in the SPD or enrollment materials for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only following the date that the election change was filed) but, as determined by the Plan Administrator.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year except as set forth in the SPD or enrollment materials.

ARTICLE IV
PREMIUM PAYMENTS AND CREDITS AND DEBITS TO ACCOUNTS

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Package Options shall be funded by Participant's Pre-Tax and/or After-Tax Contributions and/or any Non-Elective Contributions provided by the Employer. The required contributions for each of the Benefit Package Options offered under the Plan shall be made known to employees in enrollment materials. Pre-Tax or After-Tax Contributions (as elected by the Employee on the Salary Reduction Agreement and permitted by the Employer) shall equal the contributions required from the Participant less any available Nonselective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Package Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-Tax Contributions or After-Tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-Tax Contributions, plus any Non-Elective Contributions made available by the Employer, shall not exceed the aggregate cost of the Benefit Package Options elected.

4.02 Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-Tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he 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 or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

ARTICLE V
BENEFITS

5.01 Qualified Benefits. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of the aggregate maximum premium and/or contribution for all Benefit Package Option(s) set forth in the SPD or enrollment materials.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-Tax Contribution or After-Tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonselective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment materials.

ARTICLE VI
PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Supervisors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as the Benefits Administrator (or other entity) and shall be identified in the SPD and enrollment materials;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan;

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Provision for Benefits Administrator. The Plan Administrator, subject to approval of the Employer, may employ a Benefits Administrator and such other persons, as it may deem necessary or desirable in connection with the operation of the Plan and may rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the SPD and enrollment materials

as the Benefits Administrator (or other service provider). Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of their duties.

6.05 Bonding. Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses. The Employer currently pays all reasonable expenses incurred in administering the Plan.

6.07 Funding Policy. The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefit Package Options offered under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

(a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;

(c) The Employer will not be liable for the payment of any insurance premium or any loss that may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

(d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

ARTICLE VII
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD or enrollment materials. The Plan's claim review

procedures set forth in the SPD or enrollment materials shall only apply to issues germane to the Pre-Tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under this Cafeteria Plan document).

ARTICLE VIII
AMENDMENT OR TERMINATION OF PLAN

8.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.02 and 8.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

8.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g., by approval by the Board of Supervisors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Package Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this Section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer that participates in this Plan.

8.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

8.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

ARTICLE IX
GENERAL PROVISIONS

9.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

9.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of California, to the extent not preempted.

9.03 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

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

9.05 Tax Effects. Neither the Employer, nor the Plan Administrator, nor the Benefits Administrator makes any warranty or other representation as to whether any Pre-Tax Contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or

state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator, the Benefits Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

9.06 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

9.07 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

9.08 Incorporation by Reference. The actual terms and conditions of the separate component Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. In addition, the and enrollment materials for this Plan contain many of the actual terms and conditions of this Plan. To that end, the SPD, as amended from time to time, is incorporated herein.

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

9.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may be delegated to the Benefits Administrator, and may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

IN WITNESS WHEREOF, the Employer has executed this *Amended and Restated* Cafeteria Plan as of the date set forth below.

PLACER COUNTY

By:_____

Title:_____

Date:_____

APPENDIX A

PLACER COUNTY

Amended and Restated
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN
for the
PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM

Original Effective Date: July 1, 1991

The Effective Date of this Document is January 1, 2008.

HEALTH FSA PLAN

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PREAMBLE

Effective as of the Effective Date set forth below, **PLACER COUNTY** established this **Health Flexible Spending Account Plan for the Placer County Management & Confidential Team** (the "Health FSA") to help provide full and complete medical care for those Employees who participate in the Employer's *Amended and Restated* Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to contribute to a Health Care Reimbursement Account established pursuant to this Health FSA Plan.

This Health FSA Plan is intended to provide reimbursement of certain Eligible Medical Expenses incurred by the Participant and his/her eligible Dependents. The Employer intends that the Health FSA Plan qualify as a Code Section 105 self-insured medical reimbursement plan, and that the benefits provided under the Health FSA Plan be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code.

This Health FSA Plan is a component of, and incorporated by reference into, the *Amended and Restated* Cafeteria Plan for the Placer County Management & Confidential Team (the "Cafeteria Plan") and Articles VI, VII, VIII and IX of the Cafeteria Plan document apply also to this Health FSA Plan. If there is any conflict between this document and the Cafeteria Plan document with regard to the Health FSA benefit, this document shall control.

ARTICLE IA
DEFINITIONS

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

1.01A "Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 105(b).

1.02A "Effective Date" of this Health FSA means July 1, 1991. This is the date the Plan was established. It will not necessarily coincide with the date of this document as set forth in the title page.

1.03A "Eligible Medical Expenses" means those expenses that are eligible for reimbursement under this Health FSA as set forth in the SPD or enrollment materials for the applicable Plan Year (the "enrollment materials").

1.04A "Health Care Reimbursement" shall have the meaning assigned to it by Section 4.01A of this Health FSA.

1.05A "Highly Compensated Individual" means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.06A "Reimbursement Account" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and/or Non-Elective Contributions are made and retained for future Health Care Reimbursement (as defined in Section 1.04A herein). No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

ARTICLE IIA
ELIGIBILITY AND PARTICIPATION

2.01A Eligibility to Participate. All Placer County Management and Confidential Team's permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in Placer County's Component Health Plan ("Health FSA Eligibility Requirements") are eligible to participate in the Health FSA Plan on the 1st of the month following their date of hire ("Health FSA Eligibility Date").

2.02A Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD and enrollment materials.

2.03A Qualifying Leave Under Family Medical Leave Act. Notwithstanding any provision to the contrary in this Health FSA Plan, if a Participant goes on a qualifying leave under the Family Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's coverage under this Health FSA on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD or enrollment materials and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.04A Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Health FSA Plan, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD or enrollment materials and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Health FSA, the election change rules in Section 3.03A of this Health FSA Plan will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE IIIA
ELECTION TO PARTICIPATE

3.01A Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Health FSA Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Health FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.02A, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Health FSA's Waiting Period**. An Employee who becomes eligible to become a Participant in this Health FSA after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment materials. Participation will commence under this Health FSA as set forth in the SPD or enrollment materials (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an ***initial*** election period may become a Participant on a later date in accordance with Section 3.02A or 3.03A.

3.02A Annual Election Period. Each Employee who is a Participant in this Health FSA Plan or who is eligible to become a Participant in this Health FSA Plan shall be notified, prior to each Anniversary Date of this Health FSA, of his right to become a Participant in this Health FSA Plan, to continue participation in this Health FSA Plan, or to modify or to cease participation in this Health FSA Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment materials. An election is made during the Annual Election Period in the manner set forth in the SPD or enrollment materials. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD or enrollment materials.

3.03A Change of Elections. A Participant shall not make any changes to his or her election except for election changes permitted under the SPD or enrollment materials, and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility and changes pursuant to the Family Medical Leave Act. Except as provided in the SPD or enrollment materials for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only following the date that the election change was filed as determined by the Plan Administrator.

3.04A Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.04A, no new election with respect to the Health FSA Plan may be made during the remainder of the Plan Year except as set forth in the SPD or enrollment materials.

3.05A Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Health FSA Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

ARTICLE IVA
REIMBURSEMENTS

4.01A Health Care Reimbursement. Each Participant's Health FSA will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Non-Elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the Participant for Expenses incurred during the Plan Year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his Health FSA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the Run Out period set forth in the SPD or enrollment materials to provide Health Care Reimbursement for expenses incurred during the Plan Year. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor ("DOL") or Internal Revenue Service ("IRS") regulations. The maximum annual reimbursement under the Health FSA Plan shall be set forth in the SPD or enrollment materials. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD or enrollment materials.

4.02A Receiving Health Care Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year for which the Participant's election is effective provided that the substantiation requirements of Section 4.03A herein are satisfied. However, if the Employer so chooses the Participant may choose to make payment for eligible medical expenses with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the SPD or enrollment materials.

4.03A Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD or enrollment materials and provide the required substantiation set forth in the SPD or enrollment materials or as otherwise requested by the Plan Administrator (or its designee).

4.04A Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03A herein or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan

Administrator (or its designee) shall recoup the excess reimbursements in one or more of the following ways: (i) the Plan Administrator (or its designee) shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification; (ii) may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); and (iii) withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator (or its designee) is unable to recoup the excess reimbursement through the means set forth in (i) – (iii), the Plan Administrator (or its designee) will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

4.05A Reimbursement Following Cessation of Participation. Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year and before the date of participation in the Health FSA ceases so long as the claim is submitted prior to the end of the Run Out Period as set forth in the SPD or enrollment materials. Unless a COBRA election is made as set forth in the SPD or enrollment materials, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment and/or eligibility ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD or enrollment materials) shall be treated in accordance with Section 4.01A.

4.06A Coordination of Benefits Under the Health FSA. The Health FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

The Employer offers a Health Reimbursement Arrangement (HRA) for the Eligible Employees of the Management & Confidential Team, whose position assignments are in the Tahoe area. The HRA is the payor of first resort.

4.07A Disbursement Reports. The Plan Administrator (or its designee) shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Health FSA.

4.08A Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

4.09A Statements. The Plan Administrator or the Benefits Administrator may periodically furnish each Participant with a statement, showing such information as it deems reasonable and appropriate (e.g., the amounts paid or expenses incurred by the Employer in providing Health Care Reimbursement under the Health FSA).

4.10A Post-Mortem Payments. Any benefit payable under the Health FSA after the death of a Participant shall be paid to his surviving Spouse, or if no spouse, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator (or its designee) may retain such amount until the rights thereto are determined, without liability for any interest thereon.

4.11A Non-Alienation of Benefits. Except as expressly provided by the Plan Administrator, no Health FSA benefit shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Health FSA benefit shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

4.12A Mental or Physical Incompetency. Every person receiving or claiming benefits under the Health FSA shall be presumed to be mentally and physically competent and of age until the Plan Administrator (or its designee) receives a written notice, in a form and manner acceptable to it, that such

person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

4.13A Inability to Locate Payee. If the Plan Administrator (or its designee) is unable to make payment to any Participant or other person to whom a payment is due under the Health FSA because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

4.14A Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator nor Benefits Administrator makes any warranty or other representation as to whether any reimbursements made under the Health FSA will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator, the Benefits Administrator, or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Health FSA is designed and is intended to be operated as a self-insured medical reimbursement plan under Section 105 of the Code.

4.15A Forfeiture of Unclaimed Reimbursement Account Benefits. Except to the extent contrary to state law, any Health Care Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

ARTICLE VA
FUNDING AGENT

The Health FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements, and/or Non-Elective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and to the extent applicable, shall comply with all applicable regulations promulgated by the Department of Labor ("D.O.L.") taking into consideration any enforcement procedures adopted by the D.O.L.

ARTICLE VIA
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Health FSA and those claims review procedures are set forth in the SPD or enrollment materials.

ARTICLE VIIA
CONTINUATION COVERAGE UNDER COBRA

The SPD or enrollment materials include COBRA continuation of coverage provisions that shall be applicable to the Health FSA, to the extent the Employer is subject to COBRA as set forth in the relevant Code, statutory provisions and the applicable regulations promulgated thereunder.

ARTICLE VIIIA
HIPAA PRIVACY AND SECURITY

8.01A Scope and Purpose. The HRA (the "Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for

purposes related to health care treatment, payment for health care and health care operations as set forth below.

8.02A Effective Date. This Article VIII is effective on April 14, 2003 (or such later effective date of the Privacy Rules with respect to the Plan).

8.03A Use and Disclosure of PHI.

(a) General. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(b) Disclosure to the Employer. The Plan will disclose PHI to the Employer, or where applicable, an Affiliate only upon receipt of written certification from the Employer that:

(i) The Plan Document has been amended to incorporate the provisions in this Article VIIIA; and

(ii) The Employer agrees to implement the provisions in Section 8.04A herein.

8.04A Conditions Imposed on Employer. Notwithstanding any provision of the Plan to the contrary, the Employer agrees:

(a) Not to use or disclose PHI other than as permitted or required by this Article VIIIA or as required by law;

(b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;

(c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;

(d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;.

(e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIIIA, if it becomes aware of an inconsistent use or disclosure;

(f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which

disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(k) To ensure adequate separation between the Plan and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article VIIIA; and

(l) To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (other than enrollment/ disenrollment information) and it will ensure that any agents or subcontractors to whom it provides such electronic PHI agrees to implement reasonable and appropriate safeguards to protect the information.

8.05A Designated Employees Who May Receive PHI. In accordance with the Privacy Rules, only certain Employees who perform Plan administrative functions may be given access to PHI. Those Employees who have access to PHI from the Plan are listed in the Privacy Notice, either by name or individual position.

8.06A Restrictions on Employees with Access to PHI. The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan administration functions that the Employer performs for the Plan, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, and monitoring.

8.07A Policies and Procedures. The Employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

8.08A Organized Health Care Arrangement. The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

8.09A Privacy and Security Official. The Plan shall designate a Privacy and a Security Official, who will be responsible for the Plan's compliance with HIPAA's Privacy and Security Rules including, but not limited to those duties described below. The Privacy Official and the Security Official may be the same individual. The Privacy and Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy and Security Official deems necessary or advisable:

(a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article VIIIA;

(b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;

(c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;

(d) Establishing and overseeing proper training of the Plan, or Employer personnel who will have access to Protected Heath Information;

(e) Any other duty or responsibility that the Privacy and Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article VIIIA.

8.10A Non-Compliance. The Employer shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIIIA.

8.11A Definitions. As used in this Article VIIIA, each of the following capitalized terms shall have the respective meaning given below:

"Individual" means the person who is the subject of the heath information created, received or maintained by the Plan or Employer.

"Organized Health Care Arrangement" means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.

"Privacy Notice" means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

"Privacy Rules" means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

"Protected Health Information or PHI" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

8.12A Interpretation and Limited Applicability. This Article VIIIA serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article VIIIA nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIIIA are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

8.13A Services Performed for the Employer. Notwithstanding any other provision of this Plan to the contrary, all services performed by a Business Associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a Business Associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.

IN WITNESS WHEREOF, the Employer has executed this *Amended and Restated* Health FSA Plan as of the date set forth below.

PLACER COUNTY

By:_____

Title:_____

Date:_____

APPENDIX B

PLACER COUNTY

Amended and Restated
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN
for the
PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM

Original Effective Date: July 1, 1991

The Effective Date of this Document is January 1, 2008.

DEPENDENT CARE FSA PLAN

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PREAMBLE

Effective as of the date set forth below, **PLACER COUNTY** established this *Amended and Restated* **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN** (the "Dependent Care FSA" or "Dependent Care FSA Plan") to help provide dependent care assistance for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a Dependent Care FSA established pursuant to this Plan.

This Dependent Care FSA Plan is intended to provide reimbursement of certain Eligible Employment-Related Expenses incurred by the Participant for care of a Qualifying Individual. The Employer intends that the Dependent Care FSA qualify as a Code Section 129 dependent care assistance plan, and that the benefits provided under the Dependent Care FSA Plan be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code.

This Dependent Care FSA Plan is a component of, and incorporated by reference into, the *Amended and Restated* Cafeteria Plan for the PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM (the "Cafeteria Plan") and Articles VI, VIII and IX of the Cafeteria Plan document apply also to this Dependent Care FSA Plan.

ARTICLE IB
DEFINITIONS

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

1.01B "Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152 (determined without regard to subsections 152(b)(1), 152(b)(2) and 152(d)(1)(B)) except that a child with respect to whom Code Section 21(e)(5) applies who is in the custody of the parent for the longest period during the year shall be considered a dependent of such custodial parent for purposes of this Dependent Care FSA Plan.

1.02B "Dependent Care Reimbursement" shall have the meaning assigned to it by Section 4.01B of this Dependent Care FSA Plan.

1.03B "Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.04B "Effective Date" of this Dependent Care FSA Plan means July 1, 1991 for the Placer County Management and Confidential Team. This is the date the Plan was established. It will not necessarily coincide with the date of this document as set forth in the title page.

1.05B "Eligible Employment-Related Expenses" means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child (as defined in Code Section 152(f)(1)) of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.06B "Highly Compensated Individual" means an individual defined under Code Section 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.07B "Reimbursement Account" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and/or Non-Elective Contributions are made and retained for future Dependent Care Reimbursement (as defined in Section 1.02B herein). No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.08B "Qualifying Individual" means:

(a) a Qualifying Child as defined in Code Section 152(a)(1) who is under the age of thirteen (13) and except that a child of divorced parents will be considered a Qualifying Individual of the parent with whom the child resides with for the longest portion of the year without regard to who is entitled to the exemption);

(b) a Dependent of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of abode as the employee for more than half the year; or

(c) the Spouse of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of abode as the employee for more than half the year.

1.09B "Qualifying Services" means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

ARTICLE IIB
ELIGIBILITY AND PARTICIPATION

2.01B Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD and enrollment materials shall be eligible to participate in this Dependent Care FSA as of the Dependent Care Eligibility Date set forth in the SPD and enrollment materials.

2.02B Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD and enrollment materials.

2.03B Qualifying Leave Under Family Medical Leave Act. Notwithstanding any provision to the contrary in this Dependent Care FSA, if a Participant goes on a qualifying leave under the Family Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's coverage under this Dependent Care FSA in accordance with the SPD or enrollment materials. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and enrollment materials and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

ARTICLE IIIB
ELECTION TO PARTICIPATE

3.01B Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Dependent Care FSA Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator

(or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Dependent Care FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.02A, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Dependent Care FSA's Waiting Period.** An Employee who becomes eligible to become a Participant in this Dependent Care FSA after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated Benefits Administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment materials. Participation will commence under this Dependent Care FSA as set forth in the SPD or enrollment materials (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.02Bor 3.03B.

3.02B Annual Election Period. Each Employee who is a Participant in this Dependent Care FSA or who is eligible to become a Participant in this Dependent Care FSA shall be notified, prior to each Anniversary Date of this Dependent Care FSA, of his right to become a Participant in this Dependent Care FSA, to continue participation in this Dependent Care FSA, or to modify or to cease participation in this Dependent Care FSA, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment materials. An election is made during the Annual Election Period in the manner set forth in the SPD or enrollment materials. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD or enrollment materials.

3.03B Change of Elections. A Participant shall not make any changes to his or her election except for election changes permitted under the SPD or enrollment materials, and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility and changes pursuant to the Family Medical Leave Act. All election changes shall be effective on a prospective basis only following the date that the election change was filed as determined by the Plan Administrator.

3.04B Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.04B, no new election with respect to the Dependent Care FSA may be made during the remainder of the Plan Year except as set forth in the SPD or enrollment materials.

3.05B Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Dependent Care FSA may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

ARTICLE IVB
REIMBURSEMENT

4.01B Dependent Care Reimbursement. To the extent offered under the Plan, each Participant's Dependent Care FSA will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Non-Elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the Run Out Period set forth in the SPD or enrollment materials to provide Dependent Care Reimbursement for Eligible Employment-Related Expenses incurred during the Plan Year.

Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall be set forth in the SPD or enrollment materials. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD or enrollment materials.

4.02B Receiving Dependent Care Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Employment-Related Expenses incurred by him while a Participant, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 4.03B herein are satisfied.

4.03B Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD or enrollment materials and provide the required substantiation set forth in the SPD or enrollment materials or as otherwise requested by the Plan Administrator (or its designee).

4.04B Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Dependent Care FSA that exceed the amount of Eligible Employment-Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03B herein or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator (or its designee) shall recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator (or its designee) shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification. (ii) The Plan Administrator (or its designee) may offset the excess reimbursement against any other Eligible Employment-Related Expenses submitted for reimbursement (regardless of the Plan Year in which submitted) (iii) withhold such amounts from the Participant's pay (to the extent permitted under applicable law. If the Plan Administrator (or its designee) is unable to recoup the excess reimbursement through the means set forth in (i) – (iii), the Plan Administrator (or its designee) will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

4.05B Reimbursement Following Cessation of Participation. Participants in the Dependent Care FSA may submit claims for reimbursement for Eligible Employment-Related Expenses incurred during the Plan Year and before the date of their participation in the Dependent Care FSA ceases so long as the claim is submitted prior to the end of the Run Out Period set forth in the SPD or enrollment materials. To the extent set forth in the SPD or enrollment materials, Participants may submit claims for reimbursement of Eligible Employment-Related Expenses incurred during the Plan Year, during their period of coverage, so long as such claims are submitted prior to the end of the Run Out Period. Any

unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD or enrollment materials) shall be treated in accordance with Section 4.01B.

4.06B Disbursement Reports. The Plan Administrator (or its designee) shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Dependent Care FSA.

4.07B Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator or its designee.

4.08B Statements. The Plan Administrator or its designated Benefits Administrator may periodically furnish each Participant with a statement, showing such information as it deems reasonable and appropriate (e.g., the amounts paid or expenses incurred by the Employer in providing benefits under the Dependent Care FSA).

4.09B Post-Mortem Payments. Any benefit payable under the Dependent Care FSA after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator (or its designee) may retain such amount until the rights thereto are determined, without liability for any interest thereon.

4.10B Non-Alienation of Benefits. Except as expressly provided by the Plan Administrator, no Dependent Care FSA benefit shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Dependent Care FSA shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

4.11B Mental or Physical Incompetency. Every person receiving or claiming benefits under the Dependent Care FSA shall be presumed to be mentally and physically competent and of age until the Plan Administrator (or its designee) receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

4.12B Inability to Locate Payee. If the Plan Administrator (or its designee) is unable to make payment to any Participant or other person to whom a payment is due under the Dependent Care FSA because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

4.13B Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator nor the Benefits Administrator makes any warranty or other representation as to whether any reimbursements made under the Dependent Care FSA will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator, the Benefits Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Dependent Care FSA is designed and is intended to be operated as a dependent care assistance plan under Section 129 of the Code.

4.14B Forfeiture of Unclaimed Reimbursement Account Benefits. Except to the extent contrary to state law, any Dependent Care FSA Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment-Related Expense was incurred shall be forfeited.

ARTICLE VB
FUNDING AGENT

The Dependent Care FSA Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements, and/or Non-Elective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations.

ARTICLE VIB
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Dependent Care FSA and those claims review procedures are set forth in the SPD or enrollment materials.

IN WITNESS WHEREOF, the Employer has executed this Dependent Care FSA Plan as of the date set forth below.

PLACER COUNTY

By:_____

Title:_____

Date:_____

SUMMARY PLAN DESCRIPTION
For The

PLACER COUNTY

Amended and Restated **CAFETERIA PLAN**
Amended and Restated **HEALTH FLEXIBLE SPENDING ACCOUNT PLAN**
Amended and Restated **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN**
for the
PLACER COUNTY MANAGEMENT & CONFIDENTIAL TEAM

This Document is effective January 1, 2008.

SPD
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GENERAL INFORMATION ABOUT THE PLAN

PLACER COUNTY (the "Employer") is pleased to sponsor an employee benefit program known as the Placer County Management & Confidential Team Cafeteria Plan (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes ("Pre-Tax Contributions") to pay for the Benefit Options that you choose by entering into a salary reduction agreement with your Employer. This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction).

This Plan has three components:

(i) A **Cafeteria Plan** Component. The Cafeteria Plan Component allows you to pay your share of Benefit Options with Pre-Tax Contributions.

(ii) A **Dependent Care Flexible Spending Account Plan** (the "Dependent Care FSA Plan" or "Dependent Care FSA"). The Dependent Care FSA allows you to use a specified amount of Pre-Tax Contributions to be used for reimbursement of Employment-Related Expenses. The Dependent Care FSA is intended to qualify as a Code Section 129 dependent care assistance plan.

(iii) A **Health Flexible Spending Account Plan** (the "Health FSA Plan" or "Health FSA"). The Health FSA allows you to use a specified amount of Pre-Tax Contributions to be used for reimbursement of Eligible Medical Expenses. The Health FSA is intended to qualify as a Code Section 105 self-insured medical reimbursement plan.

Each of the three components is summarized in this document. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary and your enrollment materials. For example, you can find the identity of the Benefits Administrator, the Employer, and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information.

Each summary and the attached Appendices constitute the Summary Plan Description for the **Placer County** *Amended and Restated* **Cafeteria Plan,** *Amended and Restated* **Dependent Care FSA Plan**, and *Amended and Restated* Health FSA Plan for the **Management & Confidential Team.** The Summary Plan Description ("SPD") and enrollment materials describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this SPD is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan or Benefits Administrator (who are identified in the Plan Information Summary). Pursuant to a separate written agreement, the Plan Administrator has delegated many of its duties to the Benefits Administrator.

CAFETERIA PLAN COMPONENT SUMMARY

Q-1. What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow eligible employees to pay for Benefit Options with Pre-Tax Contributions. The Benefit Options to which you may contribute with Pre-Tax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Rules regarding Pre-Tax Contributions are described in more detail below.

Q-2. Who can participate in the Cafeteria Plan?

Each Employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who (i) satisfies the Plan's Eligibility Requirements and (ii) is also eligible to participate in at least one of the Benefit Options will be eligible to participate in this Plan. If you meet these requirements, you may become a Participant on the Cafeteria Plan Eligibility Date. The Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants". (See below for instructions on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105(b). The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

Q-3. When does my participation in the Cafeteria Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or
(iv) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will *automatically* cease, and you will not be able to make any more Pre-Tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a Pre-Tax basis). If you are rehired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are rehired or again become eligible within 30 days , your Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a Participant?

If you have otherwise satisfied the Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-Tax Contributions. You will be provided a Salary Reduction Agreement on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator or the Benefits Administrator (per the instructions provided with your Salary Reduction Agreement) during one of the election periods described in Q-6 below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in Q-8, below. The Benefits Administrator is identified in the Plan Information Summary.

In some cases, the Employer may *require* you to pay your share of the Benefit Option coverage that you elect with Pre-Tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan.

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are the tax advantages and disadvantages of participating in the Cafeteria Plan?

You save federal income tax, FICA (Social Security) and state income taxes (for each where applicable) by participating in the Plan. There is an example attached to this SPD that illustrates the tax savings you might experience as a result of participating in the Plan.

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits.

Q-6. What are the election periods for entering in the Cafeteria Plan?

The Cafeteria Plan basically has three election periods: (i) the "Initial Election Period," (ii) the "Annual Election Period," and (iii) the "Election Change Period, which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Plan will begin as provided by the Benefits Administrator (in no event earlier than the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received). The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in Q-8, below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. Failure to make an election under this Plan generally results in no coverage under the Benefit Options; however, the Employer may

provide coverage under certain Benefit Options automatically. These automatic benefits are called "Default Benefits." Any Default Benefits provided by your Employer will be identified in the enrollment materials. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a Pre-Tax basis. You will be notified in the enrollment materials whether there will be a corresponding Pre-Tax Contribution for such default benefits.

6b. What is the Annual Election Period?

The Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment materials distributed to you prior to the Annual Election Period. The election that you make during the Initial Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below.

If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you will be deemed to have elected to continue participation in the Plan with the same Benefit Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election." **Special Rule for Flexible Spending Accounts (FSAs): Evergreen elections do not generally apply to FSA elections. Consequently, except as otherwise provided in the enrollment materials, you must make an election each Annual Election Period in order to participate in the FSAs during the next Plan Year.**

The consequences of failing to make an election under this Plan during the Annual Election Period are described in the Plan Information Summary.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How is my Benefit Option coverage paid for under this Plan?

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-Tax Contributions. The enrollment materials you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have an option to choose to pay with After-Tax contributions.

When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-Tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with Employer Contributions. The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment materials or in the Plan Information Summary. **Special Rule for Flexible Spending Accounts: Evergreen elections do not generally apply to FSA elections. Consequently, except as otherwise provided in enrollment**

materials, you must make an election each Annual Election Period in order to participate in the FSAs during the next Plan Year.

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective Employer contributions are called "Flexible Credits" or "Benefit Credits." The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment materials.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

(a) You experience a "Change in Status Event" that affects your eligibility under this Plan and/or a Benefit Option; or
(b) You experience a significant cost or coverage change; and
(c) You complete and submit a written Election Change Form within the Election Change period described in the Plan Information Summary.

Change in Status Events and Cost or Coverage Changes recognized by this Plan, and the rules surrounding election changes in the event you experience a Change in Status Event or Cost or Coverage Change are described in the Election Change Chart attached to this SPD and enrollment materials.

Third, an election under this Plan may be modified during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the applicable federal income tax law.

If coverage under a Benefit Option ends, the corresponding Pre-Tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9. What happens to my participation under the Cafeteria Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Options) during a leave of absence. The specific election changes that you can make under this Plan following a leave of absence are described in the Election Change Chart and the rules regarding coverage under the Benefit Options during a leave of absence will be described in the Benefit Option summaries. If there is a conflict between the Election Change Chart/ Benefit Option Summaries and this Q-9 and the enrollment materials, the Election Change Chart or Benefit Option summary, whichever is applicable, controls.

(a) If you go on a qualifying unpaid leave under the Family Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you

will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-Tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) with After-Tax Dollars while you are on leave, or

(ii) by other arrangements agreed upon between you and the Employer (for example, the Employer may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Employer. The Election Change Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

(f) Except as otherwise provided by your Employer, if you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by After-Tax Contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if my request for a benefit under this Cafeteria Plan is denied (e.g. an election change or other issue germane to Pre-Tax Contributions)?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

HEALTH FSA COMPONENT SUMMARY

Q-1. Who can participate in the Health FSA?

All Placer County Management and Confidential Team's permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in Placer County's Component Health Plan ("Health FSA Eligibility Requirements") are eligible to participate in the Health FSA Plan on the 1st of the month following their date of hire ("Health FSA Eligibility Date").

Q-2. How do I become a Participant?

If you have otherwise satisfied the Health FSA's Eligibility requirements, you become a Participant in the Health FSA by electing the Health Care Reimbursement benefit during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health FSA will be effective on the date that you make the election or your Health FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Except as otherwise provided in enrollment materials, evergreen elections do not apply to Health FSA elections.

You may also become a Participant if you experience a change in status event that permits you to enroll mid year (see Q-8. of the Cafeteria Plan Summary for more details regarding mid year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

(i) Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and
(ii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE: Your participation in this Health FSA could disqualify your Spouse from establishing and making/ receiving tax-favored contributions to a Health Savings Account (HSA) as defined in Code Section 223.

Q-3. What is my "Health Care Account?"

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Account" to keep a record of the reimbursements to which you are entitled, as well as the Pre-Tax Contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Health FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in Q-16. below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;
(ii) The date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
(iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5. Can I change my Health FSA election during the Plan Year?

You can change your election under the Health FSA in the following situations:

(i) *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event.* You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See Q-8. of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes.**

Q-6. What happens to my Health Care Account if I take an approved leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7. What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary or enrollment materials. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Non-Elective Flex Credits allocated to your Health Care Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated Benefits Administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Health Care Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-Tax Contributions and/or Non-Elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment materials will indicate if Non-Elective Contributions or Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-Elective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Q-9. What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Plan Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

Q-10. How do I receive reimbursement under the Health FSA?

If your Employer offers the Electronic Payment Card under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, if applicable, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay for the eligible expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Benefits Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Benefits Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription medication or over-the-counter)
4. Amount of reimbursable expense under the plan
5. Date(s) of service.

The Benefits Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

Electronic Payment Card: If your Employer offers this option, the Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must generally make an election to use the card (see your enrollment materials for the applicable Plan Year).* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan ends. The enrollment materials for the applicable Plan Year will specify whether the card may be used during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your HEALTH FSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *Health care reimbursement under the card is limited to health care providers (including pharmacies) and IIAS certified merchants.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.) or have established an IRS-approved IIAS system pursuant to IRS Notice 2006-69 and any subsequent guidance. As set forth in the Cardholder Agreement, you will not be able to use the card at certain retail stores.

(e) *You use the card at the health care provider or IIAS-certified merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office, such as a co-payment, you use the card at the provider's office much like you would a typical credit or debit card. You present the card to the pharmacist of participating pharmacies like you do a prescription drug card. The card pays your eligible prescription drug expenses not covered by insurance or your drug plan. The provider is paid for the expense up to the maximum reimbursement amount available under the Health FSA (or as otherwise limited by the Program) at the time that you use the card. Every time you use the card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

(f) *You must obtain and retain a receipt/ third-party statement each time you use the card. Each time you use the card,* a written statement (e.g., a receipt, EOB, etc.) from the health care provider and/or IIAS-certified merchant, associated with each Eligible Medical Expense, must indicate the following:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The date the expense was incurred.
- The amount of the expense.
- The provider's name
- The patient's name.

NOTE: If available in the normal course of business, you must submit an Explanation of Benefits (EOB) for your third-party statement with your claim.

You must retain your written statements/ receipts for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the card arrangement, a written third-party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a notification from the Benefits Administrator if a third-party statement is needed. You must provide the third-party statement to the Benefits Administrator within 7 days (or such longer period provided in the notification from the Benefits Administrator) of the request.

(g) *There are situations where the third-party statement will not be required to be provided to the Benefits Administrator.* There may be situations in which you will not be required to provide the written statement to the Benefits Administrator. More detail as to which situations apply under your Plan can be obtained by contacting the Plan Administrator or Benefits Administrator:

- **Co-Pay Match:** Written statements may not be necessary if the Electronic Payment Card payment matches a specific co-payment you have under the Component Medical Plan for the particular service that was provided. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you may not be required to provide the third-party statement to the Benefits Administrator.

- **Previously Approved Claim Match:** Written statements may not be required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the Benefits Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is used for subsequent refills at ABC Pharmacy the receipt may not need to be provided to the Benefits Administrator if the expense incurred is the same amount.

- **Provider Match Program:** Third-party statements may not be required to be submitted to the Benefits Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider or IIAS-certified merchant that identifies the nature of your expense and verifies the amount.

Note: You should still obtain the third-party receipt when you incur the expense and use the card, even if you think it will not be needed, so that you will have it in the event the Benefits Administrator does request it.

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Benefits Administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, your usage of the card may be terminated by the Employer.

(i) The Benefits Administrator may offset any improperly paid claims by substituting other paper claims or by withholding a portion of the total reimbursement payment of a paper claim until the outstanding transaction is paid in full.

(j) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for

which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Q-11. What is an "Eligible Medical Expense?"

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d);
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

In no event will the following expenses be eligible for reimbursement:

a) any expense that is not a Code Section 213(d) expense

b) any expenses incurred for qualified long term care services (as defined in Code Section 106)

c) expenses incurred *prior to the date* that coverage under this Health FSA becomes effective

d) expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Benefits Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of over the counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Benefits Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

NOTE: Your participation in this Health FSA could disqualify your Spouse from establishing and making/ receiving tax-favored contributions to a Health Savings Account (HSA) as defined in Code Section 223.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than

48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. Special rules apply with regard to orthodontia expenses. Contact the Benefits Administrator. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run Out period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Employer's sole discretion).

Q-14 What happens if a Claim for Benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-15. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited. Forfeitures shall be subject to state escheat requirements.

Q-16. What is COBRA continuation coverage?

Federal law requires most private and governmental Employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the Employer is a "small Employer" or the Health FSA is a church Plan). The Benefits Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the Employer (if a Employer is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the Employer is notified that one of these events has occurred, the Benefits Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

An employee or covered Dependent is responsible for notifying the Employer if he or she becomes covered under another group health plan.
Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the Employer

identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

Q-17. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Employer may recoup the excess reimbursements in one or more of the following ways: (i) the Employer (or its designee) will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification; (ii) the Employer (or its designee) may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Employer (or its designee) may withhold such amounts from your pay (to the extent permitted under applicable law). If the Employer (or its designee) is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-18. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer and Benefits Administrator's health privacy policies.

Q-19. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Q-20. How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) sponsored by the Employer?

The Employer offers a Health Reimbursement Arrangement (HRA). The HRA is the payor of first resort.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

To the extent the Health FSA is subject to HIPAA's portability rules, you may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

DEPENDENT CARE FSA PLAN COMPONENT SUMMARY

Q-1. Who can participate in the Plan?

All Placer County Management and Confidential Team's permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in Placer County's Component Health Plan ("Dependent Care FSA Eligibility Requirements") are eligible to participate in the Health FSA Plan on the 1st of the month following their date of hire ("Dependent Care FSA Eligibility Date").

Q-2. How do I become a Participant?

If you have otherwise satisfied the Dependent Care FSA's Eligibility Requirements, you become a Participant in the Dependent Care FSA Plan by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in Q-6 of the Cafeteria Plan Summary. Your participation in the Dependent Care FSA Plan will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must generally make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections unless otherwise specified in your enrollment materials.

You may also become a Participant if you experience a Change in Status event or Cost or Coverage change that permits you to enroll mid year (see Q-8. of the Cafeteria Plan Summary and the enrollment materials for more details regarding mid-year election changes and the effective date of those changes).

Q-3. What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefit during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. When does my coverage under the Dependent Care FSA Plan end?

Your coverage under the Dependent Care FSA Plan ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

Except as otherwise provided in your enrollment materials, if you terminate employment or you cease to be eligible during the Plan Year, you **cannot** submit for reimbursement otherwise Eligible Employment-Related Expenses incurred **after** the date of separation.

Q-5. Can I change my Dependent Care FSA election during the Plan Year?

You can change your election under the Dependent Care FSA in the following situations:

(i) *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. If you do not make a new election, your Dependent Care FSA participation will cease (unless otherwise provided in your enrollment materials). The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event or Cost or Coverage Change.* You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant Cost or Coverage change. See Q-8. of the Cafeteria Plan Summary and the enrollment materials for more information on election changes.

Q-6. What happens to my Dependent Care Account if I take an unpaid leave of absence?

Refer to the Cafeteria Plan Summary, the Election Change Chart and the enrollment materials to determine what, if any, specific changes you can make during a leave of absence.

Q-7. What is the minimum and maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The minimum annual amount elected by a Participant cannot be less than $130 annually or $5.00 per pay period.

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you -

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your Spouse's earned income.

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is

(i) physically or mentally incapable of caring for himself or herself, or

(ii) a full-time student (as defined by Code Section 21).

Q-8. How Do I Pay for Dependent Care Reimbursements?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-Tax Contributions and/or Non-Elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment materials will indicate if Non-Elective Employer Contributions (or Benefit Credits) are available for Dependent Care FSA coverage.

Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-Elective Employer Contributions (or Benefit Credits) allocated to your Dependent Care Account.

Q-9. What Is an "Eligible Employment-Related Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Employment-Related Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Employment-Related Expense:

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

   (i) An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step-sibling, etc.) of the Employee or a descendant of such child (e.g., a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her own support; or

   (ii) A Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

   Note: There is a special rule for children of divorced parents. The child is a qualifying individual of the "custodial parent" as defined in Code Section 152(e).

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible, unless otherwise permitted under federal law. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spend at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Employment-Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-10. How do I receive reimbursement under the Dependent Care FSA?

Under this Dependent Care FSA, you will complete and submit a written claim for reimbursement and take certain steps to be reimbursed for your Eligible Employment-Related Expenses. When you incur an Eligible Employment-Related Expense, you submit a written claim to the Plan's Benefits Administrator. You may obtain a Request for Reimbursement form from the Plan Administrator or Benefits Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a bill from the day care provider, etc.) associated with each expense that indicates the following:

a) The nature of the expense;
b) The date the expense was incurred; and
c) The amount of the expense.

If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment-Related-Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your Account balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available credits to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment-Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Employment-Related-Expenses must be incurred ***during*** the Plan Year and before your participation in the Plan ceases. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, incurred after your terminate employment, incurred after the close of the Plan Year, and unless noted otherwise in the Plan Information Summary, after your participation in the Dependent Care FSA ends.

Q-12. What if the Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment-Related Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the Run Out Period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

Q-13. Will I be taxed on the Dependent Care Reimbursement benefit I receive?

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-14. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care tax credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment-Related Expenses may be eligible for the dependent care tax credit.

Q-15. What is the household and dependent care tax credit?

The household and dependent care tax credit is an allowance for a percentage of your annual, Eligible Employment-Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your Adjusted Gross Income (AGI), the percentage could be as much as 35% of your Eligible Employment-Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your AGI over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment-Related Expenses of $3,600, and that your AGI is $21,000. Since only one Qualifying Individual is involved, the tax credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your AGI over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your tax credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-16. What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment-Related Expense was incurred shall be forfeited. Forfeitures shall be subject to state escheat requirements.

Q-17. What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to your enrollment materials and Appendix IV for a detailed summary of the Claims Procedures under this Plan.

Q-18. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Employment-Related Expenses that have been properly substantiated during the Plan Year, as set forth in this SPD or enrollment materials, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Benefits Administrator may recoup the excess reimbursements in one or more of the following ways: (i) the Benefits Administrator will notify

you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification; (ii) the Benefits Administrator may offset the excess reimbursement against any other Eligible Employment-Related Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Benefits Administrator is unable to recoup the excess reimbursements by the means set forth in (i) – (iii), the Benefits Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

Q-19. How long will the Dependent Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

PLAN INFORMATION SUMMARY

This Appendix provides information specific to the Placer County Management & Confidential Team Cafeteria Plan (the "Plan"). **The Effective Date of this Plan Information Summary is January 1, 2008.** *This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.*

I. EMPLOYER/ PLAN SPONSOR/ BENEFITS ADMINISTRATOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Placer County 145 Fulweiler Avenue Suite 200 Auburn, CA 95603 1.530.889.4060
2. Name, address, and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate, pursuant to the terms of a benefits administration agreement certain responsibilities to the Benefits Administrator.	Placer County 145 Fulweiler Avenue Suite 200 Auburn, CA 95603 1.530.889.4060 c/o Nancy Nittler, Personnel Director
3. Employer's federal tax identification number:	94-600527
4. Plan Number:	501
5. Effective Date of the Plan: This is the date that the Plan was first established.	July 1, 1991
6. Effective Date of this SPD Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.	January 1, 2008
7. Plan Year:	January 1 through December 31
8. Adopting Employers participating in the Plan:	N/A
9. Benefits Administrator:	Fringe Benefits Management Company (FBMC) 3101 Sessions Road Tallahassee, FL 32303 1.800.342.8017 webcustomerservice@fbmc-benefits.com For Claims: P. O. Box 1800 Tallahassee, FL 32303-1800

II. CAFETERIA PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date**. All Placer County Management & Confidential Team's permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in a Placer County Component Health Plan ("Cafeteria Plan Eligibility Requirements) will be eligible to participate in this Plan, on the dates listed beside each Benefit Option below ("Cafeteria Plan Eligibility Date"):

CAFETERIA PLAN BENEFIT OPTIONS	ELIGIBILITY DATES
401(k) Contributions	1st of the month following date of hire.
AD&D Insurance	30 days following date of hire. Employees have a 30 day window from date of hire to sign up for AD&D insurance.
Dental Insurance	30 days following date of hire. Employees have a 30 day window from date of hire to sign up for dental insurance.
Dependent Care FSA Plan	1st of the month following date of hire.
Health FSA	1st of the month following date of hire.
Health Insurance	1st of the month following date of hire. Employees have a 60 day window from date of hire to sign up for health insurance.
Vision Insurance	30 days following date of hire. Employees have a 30 day window from date of hire to sign up for vision insurance.

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in this SPD.

Eligibility for coverage under any given Benefit Option shall be determined not by this Plan but by the terms of that Benefit Option.

(b) **Annual Election Rules**. With respect to Benefit Option elections (other than the Dependent FSA elections), failure to make an election during the Annual Election Period will result in the following deemed election(s):

- any Employer contribution shall be converted to cash and all applicable taxes applied; and
- the Employee will be deemed to have elected to continue his or her Benefit Option elections in effect as of the end of the Plan Year in which the initial Annual Election Period took place, unless the Employee files an election to not participate in the Plan. This is called an "Evergreen Election" or "Rolling Election."

To the extent set forth in the SPD or enrollment materials, if an Employee declines enrollment for himself under any of the Employer's Component Health Plans, the Employer's Non-Elective Contribution designated for such coverage will automatically be placed into a 401(k) for said Employee.

Open enrollment materials will be distributed to all employees each year and may include a copy of their current elections. The use of evergreen elections will be disclosed in all open enrollment materials and in the *initial* Salary Reduction Form signed by the employee.

(c) **Change of Election Period**: If you experience a Change in Status Event or Cost or Coverage Change as described in the Cafeteria Plan Summary and in the Election Change Chart, you may make the permitted election changes described in the Election Change Chart if you complete and submit an election change form within 30 days after the date of the event. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

(d) **Benefit Options**: The Employer elects to offer to eligible Employees the following Benefit Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Options. These Benefit Option(s) are specifically incorporated herein by reference. The maximum Pre-Tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Options selected reduced by any Non-Elective Contributions made by the Employer. It is intended that such Pre-Tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

The following Benefit Options are made available under the Plan to all those Eligible Employees who make an appropriate election:

401(k) Salary Deferrals

AD&D Insurance
Dental Insurance
Health Insurance
Vision Insurance

Dependent Care FSA Plan
Health FSA Plan

III. HEALTH FSA COMPONENT INFORMATION

(a) **Health FSA Eligibility Requirements and Eligibility Date**. All Placer County Management & Confidential Team's permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in a Placer County Component Health Plan ("Health FSA Eligibility Requirements") are eligible to participate in the Health FSA Plan on the first day of the month following their date of hire ("Health Care FSA Eligibility Date").

(b) **Annual Health Care Reimbursement Amounts**. The Maximum Annual Reimbursement Amount each year may not exceed the lesser of Health Care Reimbursement amount elected for that year or $2000. The minimum reimbursement amount that may be elected under the Health FSA is $10.00 per bi-weekly contribution.

(c) **Run Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

(i) The Run Out Period for active employees ends March 31st.

(ii) The Run Out Period for terminated employees ends March 31st of the following year (for eligible expenses incurred during the Eligible Employee's period of coverage during the immediately preceding Plan Year).

(d) **Employer**. The Employer for the Health FSA Plan is Placer County.

(e) **Interaction With HRA.** The Employer offers a Health Reimbursement Arrangement (HRA) to Placer County Management & Confidential Team's permanent employees whose position assignment is the Tahoe area and who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in a Placer County Component Health Plan. The HRA is payor of first resort.

(f) **Method of Funding**. Health FSA benefits are paid from the Employer's general assets.

IV. DEPENDENT CARE FSA COMPONENT INFORMATION

(a) **Dependent Care FSA Eligibility Requirements and Eligibility Dates.** All Placer County Management & Confidential Team's permanent employees whose position assignment is the Tahoe area and who work a minimum of 20 hours per week, or 40 hours per pay period, and who are eligible to participate in a Placer County Component Health Plan ("Dependent Care FSA Eligibility Requirements") are eligible to participate in the Dependent Care FSA Plan on the first of the month following his or her date of hire ("Dependent Care FSA Eligibility Date").

(b) **Run Out Period.** The Run Out Period is the period during which eligible expenses incurred by Participants during their period of coverage during a Plan Year must be submitted to be eligible for reimbursement.

(ii) The Run Out Period for active employees ends March 31st.

(ii) The Run Out Period for terminated employees ends March 31st of the following year (for eligible expenses incurred during the Employee's period of coverage during the immediately preceding Plan Year.

(c) **Expense incurred after termination of employment.** You will not be reimbursed for otherwise Eligible Employment-Related Expenses incurred after you terminate employment.

(d) **Method of Funding.** Dependent Care FSA Benefits are paid from the Employer's general assets.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The Effective Date of this Appendix I is January 1, 2008. It should replace and supersede any other Appendix I with an earlier date.

The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Dependant Care FSA and Health Care FSA.

Step 1: *Notice is received from Benefits Administrator.* If you are denied a Dependant Care FSA or Health Care FSA benefit under the Plan, you will receive written notice from the Benefits Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Benefits Administrator, the Benefits Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Benefits Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Benefits Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial; and
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Benefits Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Benefits Administrator.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Benefits Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Benefits Administrator.

Step 6: *If you still disagree with the Benefits Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Benefits Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Benefits Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information
- You cannot file suit in federal court until you have exhausted these appeals procedures

APPENDIX II

TAX ADVANTAGES EXAMPLE

The Effective Date of this Appendix II is January 1, 2008. *It should replace and supersede any other Appendix II with an earlier date.*

As indicated in the SPD, participating in the Plan can actually increase your take home pay. Consider the following example:

> *You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the Employee-only premium, plus $2,000 for family coverage under the Employer's Component Medical Plan). You earn $50,000 and your Spouse (a student) earns no income. You file a joint tax return.*

	If you participate in the Cafeteria Plan	**If you do not participate in the Cafeteria Plan**
Gross Income	$50,000	$50,000
Salary Reductions for Premiums	**$ 2,400 (*Pre-Tax*)**	**$ 0**
Adjusted Gross Income (AGI)	$47,600	$50,000
Standard Deduction	($ 9,700)	($ 9,700)
Exemptions	($ 9,300)	($ 9,300)
Taxable Income (TI)	$28,600	$31,000
Federal Income Tax (*TI x Applicable Tax Schedule*)	($ 3,590)	($ 3,950)
FICA Tax (*7.65% x AGI*)	($ 3,641)	($ 3,825)
After-Tax Contributions	($ 0)	($ 2,400)
Pay after taxes and contributions	$40,365	$39,821
Take Home Pay Difference	**$ 544**	

APPENDIX III

ELECTION CHANGE CHART

The Effective Date of this Appendix III is January 1, 2008. *It should replace and supersede any other Appendix II with an earlier date.*

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Option, no election change is permitted under the Plan. Likewise, a Benefit Option may allow an election change that is not permitted by this Plan. In that case, your pre-tax reduction may not be changed even though a coverage change is permitted.

First, we describe the general rules regarding election changes that are established by the IRS. Then, you should look to the Election Change Chart to determine under what circumstances you are permitted to make an election change under this Plan and the scope of the changes you may make.

1. **Change in Status**. Election changes may be allowed if a Participant or a Participant's Spouse or Dependent experiences one of the Change in Status Events set forth in the following chart. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated Benefits Administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the Benefits Administrator but it may be earlier depending on the Employer's internal policies or procedures). As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the Change in Status affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

    - *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which types of election changes are consistent with the Change in Status rules. For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

      Example: *Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the plan while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.*

    - *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

another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in the Participant's, the Participant's Spouse's, or the Participant's Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefit.* With respect to the Dependent Care FSA benefit, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

  Example: *Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.*

- *AD&D.* For the accidental death and dismemberment benefit only, if a Participant experiences any Change in Status (as described above), an election to increase, decrease or cease coverage is permitted, even when eligibility is not affected.

  Example: *Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds AD&D coverage (and other benefits) through salary reduction. Before the plan year, Mike elects AD&D insurance coverage. Mike and Sharon subsequently divorce during the Plan Year. The divorce constitutes a Change in Status. An election by Mike to add a dependent, drop a dependent, or cease his AD&D coverage would each be consistent with this Change in Status.*

2. **Special Enrollment Rights.** If a Participant, Participant's Spouse and/or Dependent are entitled to special enrollment rights under a Benefit Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise Eligible Employee declined enrollment in medical plan coverage for the Employee or the Employee's Eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), the Employee may be able to elect medical coverage under the Plan for the Employee and his or her Eligible Dependents who lost such coverage. Furthermore, if an otherwise Eligible Employee gains a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may also be able to enroll the Employee, the Employee's Spouse, and the Employee's newly-acquired Dependent, provided that a request for enrollment is made within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan summary description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires a Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) covers the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or MediCal.** If a Participant or the Participant's Dependents become entitled to Medicare or MediCal, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Dependents who have been entitled to Medicare or MediCal loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the cost of a Benefit Option significantly increases, a Participant may choose either to make an increase in contributions, revoke the election and receive coverage under another Benefit Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists.* If the cost of a Benefit Option significantly decreases, a Participant who elected to participate in another Benefit Option may revoke the election and elect to receive coverage provided under the Benefit Option that decreased in cost. In addition, otherwise Eligible Employees who elected not to participate in the Plan may elect to participate in the Benefit Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Option options, however, Pre-Tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator (or its designated Benefits Administrator) will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Health FSA, to the extent offered under the Plan.)

   Example: *Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.*

6. **Change In Coverage.** If coverage under a Benefit Option is significantly curtailed, a Participant may elect to revoke his or her election and elect coverage under another Benefit Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage.

   Finally, a Participant may change his or her election to add coverage under this Plan for the Participant, the Participant's Spouse or Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (or its designated Benefits Administrator) will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to a Health FSA, to the extent one becomes offered under the Plan.)

7. **IRC § 401(k) Salary Deferrals.** The Cafeteria Plan includes a 401(k) plan feature.

   A Participant who has elected to participate in the 401(k) option under the Cafeteria Plan may change his or her deferral amount under the 401(k) option during a Plan Year. An Employee who makes a mid-year reduction to an existing 401(k) election under the Cafeteria Plan may be limited to receiving the difference as taxable compensation; additional non-taxable benefits cannot be elected unless another permitted election change event has occurred that would allow the elections for these benefits to be changed.

   NOTE: To the extent set forth in the Summary Plan Description or enrollment materials, if an Employee declines enrollment for himself under any of the Employer's Component Health Plans, the Employer's Non-Elective Contribution designated for such coverage will automatically be placed into a 401(k) for said Employee.

NOTE: In applying the permitted election change regulations, you cannot make an election change unless the change is also permitted under the terms of the underlying Benefit Option. For example, even though a cafeteria plan may allow an election change for AD&D coverage when an employee switches from part-time to full-time, the underlying AD&D policy may not allow such a change or may require underwriting.

The following is a chart reflecting the election changes that may be made under the Plan with respect to each Benefit Option. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Options. If an election change is permitted by this Plan but not by the Benefit Option, no election change under this Plan is permitted.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
I. CHANGE IN STATUS					
A. Change in Employee's Legal Marital Status					
1. Gain Spouse (Marriage)	• Employee may enroll or increase election for newly-eligible spouse and dependent children • Under IRS "tag-along" interpretation, new and pre-existing dependents may be enrolled. • Coverage option (e.g., HMO to PPO) change may not be made on account of this event. • Also, see HIPAA special enrollment rule below.	• Same as previous column. • HIPAA special enrollment rights likely do *not* apply.	• Employee may enroll or increase election for newly-eligible spouse and dependents • Employee may decrease election if employee or dependents become an eligible dependent under new spouse's health plan. • HIPAA special enrollment rules may not apply.	Employee may enroll or increase to accommodate newly-eligible dependents or decrease or cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
2. Lose Spouse • Divorce, legal separation, annulment, death of spouse • See loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation, etc.	• Employee may revoke election only for spouse. • Employee may elect coverage for self or dependents who lose eligibility under spouse's plan if such individual loses eligibility as a result of the event • Coverage option (e.g., HMO to PPO) change may not be made on account of this event. • Under IRS "tag-along" interpretation, any dependents may be enrolled so long as at least one dependent has lost coverage	• Same as previous column. • HIPAA special enrollment rights may *not* apply.	• Employee may decrease election to reflect loss of spouse's eligibility. • Employee may enroll or increase election where coverage is lost under spouse's health plan.	Employee may enroll or increase to accommodate newly-eligible dependents (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
	under the spouse's plan.				
B. Change in the Number of Employee's Dependents					
1. Gain Dependent (Birth, Adoption)	• Employee may enroll or increase election for newly-eligible dependent children • Under IRS "tag-along" interpretation, new and pre-existing dependents may be enrolled. • Coverage option (e.g., HMO to PPO) change may not be made on account of this event. • Employee may revoke or decrease employee's or dependent's coverage if employee becomes eligible under spouse's plan. • Also, see HIPAA special enrollment rule below.	• Same as previous column. • HIPAA special enrollment rights likely do *not* apply.	Same as previous column.	Employee may enroll or increase to accommodate newly-eligible dependents (and any other dependents who were not previously covered under IRS "tag-along" rule).	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
2. Lose Dependent (Death)	• Employee may drop coverage only for the dependent who loses eligibility. • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event.	Same as previous column.	Same as previous column.	Employee may decrease election for dependent who loses eligibility.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
C. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility					
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility					
a. Commencement of Employment by Employee or Other Change in Employment Status (e.g., PT to FT, hourly to salaried, etc.) Triggering Eligibility Under Component Plan	• Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event.	Same as previous column.	Same as previous column.	Same as previous column.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
b. **Commencement of Employment by Spouse or Dependent or Other Employment Event Triggering Eligibility Under Their Employer's Plan**	• Employee may revoke or decrease election as to employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage. • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event	Same as previous column.	Employee may decrease or cease election if gains eligibility for health coverage under spouse's or dependent's plan.	• Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). • Employee may revoke election as to dependent's coverage if dependent is added to spouse's plan.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility					
a. **Termination of Employee's Employment or Other Change in Employment Status** (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc.) Resulting in a Loss of Eligibility	• Employee may revoke or decrease election for employee, spouse or dependent who loses eligibility under the plan. • Coverage option (HMO to PPO) change may *not* be made on account of this event	Same as previous column.	Employee may revoke election to reflect loss of eligibility (note that under most health FSAs, employee loses coverage automatically).	Employee may revoke or decrease election to reflect loss of eligibility.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
i. **Termination and Rehire Within 30 Days**	Prior elections at termination are reinstated unless another event has occurred that allows a change	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
ii. **Termination and Rehire After 30 Days**	Employee may make new elections.	Same as previous column.	Same as previous column.	Same as previous column.	Same as previous column.
b. **Termination of Spouse's or Dependent's Employment** (or other change in employment status resulting in a loss of eligibility under their employer's plan)	• Employee may enroll or increase election for employee, spouse or dependent who loses eligibility under spouse's or dependent's employer's plan. • Other previously eligible dependents may also be enrolled under "tag-along" rule. • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event. • See, HIPAA special enrollment rules below.	• Same as previous column • HIPAA special enrollment rights likely do not apply.	Employee may enroll or increase election to reflect loss of eligibility for health coverage.	• Employee may enroll or increase if spouse or dependent loses eligibility for Dependent Care FSA. • Employee may decrease or cease Dependent Care FSA election if spouse's loss of employment renders dependents ineligible.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
D. Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements (Also see discussion of gain/loss of eligibility under dependent or spouse's employer's plan)					
1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (attaining a specified age, becoming single, becoming a student, etc.)	• Employee may enroll or increase election for affected dependent. • Employee may add previously eligible (but not enrolled) dependents under "tag-along" rule. • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event.	Same as previous column.	Employee may increase election or enroll only if dependent gains eligibility under health FSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
2. Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer's Plan (attaining a specified age, getting married, ceasing to be a student, etc.)	• Employee may decrease or revoke election only for affected dependent. • Coverage option (e.g., HMO to PPO) change may *not* be made on account of this event.	Same as previous column.	Employee may decrease or revoke election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost. If dependent remains a tax dependent and the health FSA provides that the dependent's expenses remain eligible for reimbursement, then the employee could increase health FSA election.	Employee may decrease or drop election to take into account expenses of affected dependent.	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
E. Change In Place of Residence of Employee, Spouse, or Dependent					
1. Move Triggers Eligibility	• Employee may enroll or increase election for newly eligible employee, spouse, or dependent • Other previously eligible dependents may be enrolled under "tag-along" rule. • Coverage option (e.g., HMO to PPO) change may be made.	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may add a dependent, drop a dependent or cease coverage even when eligibility is not affected.
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO service area)	• Employee may revoke election or make new election if the change in residence affects the employee's, spouse's or dependent's eligibility	Same as previous column.	No change allowed, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in	Employee may add a dependent, drop a dependent or cease

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
	for coverage option. • HIPAA special enrollment rights may also apply.			coverage below).	coverage even when eligibility is not affected.
II. **COST CHANGES WITH AUTOMATIC INCREASE / DECREASE IN ELECTIVE CONTRIBUTIONS** (including employer motivated changes and changes in employee contribution rates)	Plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as previous column.	No change permitted.	Plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as Major Medical column.
III. **SIGNIFICANT COST CHANGES**	• ***Increase***: Affected employee may increase election correspondingly OR revoke election and elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, employee may revoke election. Tag-along concepts may apply. • ***Decrease***: Employees may decrease election correspondingly or may elect coverage (even if had not participated before) with decreased cost, and may drop election for similar coverage option.	Same as previous column.	No change permitted.	• Same as Major Medical column for significant cost increase, except no change can be made when the cost change is imposed by a dependent care provider who is a relative of the employee. The relative cannot be the employee's tax dependent. • See previous discussion regarding significant cost decreases.	Same as Major Medical column.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
IV. SIGNIFICANT COVERAGE CURTAILMENT	• ***Without* Loss of Coverage:** Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option that provides similar coverage. • ***With* Loss of Coverage:** Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option that provides similar coverage, OR drop coverage if no similar benefit package option is available.	Same as previous column.	No change permitted.	Election change may be made whenever there is a change in provider or a change in hours of dependent care.	Same as Major Medical column.
V. ADDITION OR SIGNIFICANT IMPROVEMENT OF BENEFIT PACKAGE OPTION	• Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option. • Other previously eligible dependents may be enrolled under "tag-along" rule.	Same as previous column.	No change permitted.	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option.	Same as previous column.
VI. CHANGE IN COVERAGE UNDER OTHER EMPLOYER CAFETERIA PLAN OR QUALIFIED BENEFITS PLAN					
1. Other Employer Plan Increases Coverage	No change permitted.	No change permitted.	No change permitted.	No change permitted.	No change permitted.
2. Other Employer's Plan Ceases Coverage	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received	Same as previous column.	No change permitted.	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or	Same as previous column.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
	corresponding decreased coverage under other employer plan.			dependents have elected or received corresponding decreased coverage under other employer plan.	
3. Open Enrollment Under Other Employer Plan / Different Plan Year	No change permitted.	No change permitted.	No change permitted.	No change permitted.	No change permitted.
VII. LOSS OF GROUP HEALTH COVERAGE SPONSORED BY GOVERNMENTAL OR EDUCATIONAL INSTITUTION	• Employee may enroll or increase election for employee, spouse, or dependent if employee, spouse, or dependent loses group health coverage sponsored by governmental or educational institution. • If employee loses individual coverage, he may add coverage for family members as well.	Same as previous column.	No change permitted.	No change permitted.	No change permitted.
VIII. HIPAA SPECIAL ENROLLMENT RIGHTS					
A. Special Enrollment for Loss of Other Health Coverage (e.g., COBRA coverage exhausted or terminated; no longer eligible for non-COBRA coverage or employer contributions for non-COBRA coverage terminated, etc.)	• Employee may elect coverage for employee, spouse, or dependent who has lost other coverage • Other previously eligible dependents may be enrolled under "tag-along" rule.	No change permitted, unless plan is subject to HIPAA portability rules.	No change permitted, unless plan is subject to HIPAA portability rules.	No change permitted.	No change permitted.
B. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption (If newborn or newly adopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to	• Employee may elect coverage for employee, spouse, or dependent. • Election of coverage may also extend to previously eligible (but not yet enrolled) dependents.	No change permitted, unless plan is subject to HIPAA portability rules.	No change permitted, unless plan is subject to HIPAA portability rules.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
date of birth, adoption, or placement for adoption. Employee may change salary reduction elec-tion to pay for extra cost of child's coverage retroactive to date of birth, adoption, or placement for adoption. For marriage, coverage is effective only prospectively.					
IX. JUDGMENTS, DECREES OR ORDERS					
A. Order That Requires Coverage for the Child Under Employee's Plan	• Employee may change election to provide coverage for the child. • Election of coverage may also extend to previously eligible (but not yet enrolled) dependents.	Same as previous column.	Same as previous column.	No change permitted.	No change permitted.
B. Order That Requires Spouse, Former Spouse, or Other Individual to Provide Coverage for the Child	Employee may change election to cancel coverage for the child.	Same as previous column.	Same as previous column.	No change permitted.	No change permitted.
X. MEDICARE OR MEDICAL					
A. Employee, Spouse, or Dependent Enrolled in Employer's Accident or Health Plan Becomes Entitled to Medicare or MediCal *(other than coverage solely for pediatric vaccines)*	Employee may elect to cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Unlikely that employee can elect to drop dental or vision coverage; presumably, employee must retain coverage.	Employee may decrease or revoke election under employer plan.	No change permitted.	No change permitted.
B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or MediCal *(other than coverage solely for pediatric*	• Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable.	No change permitted.	Employee may commence or increase election under employer plan.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
vaccines)	• Election of coverage may also extend to previously eligible (but not yet enrolled) dependents.				
XI. FMLA LEAVES OF ABSENCE					
A. Employee's Commencement of FMLA Leave	• Employee can make same election changes as employee on non-FMLA leave. • Employer must allow employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow employee to discontinue payment of his or her share of the contribution during the leave. The employer may recover the employee's share of contributions when the employee returns to work. • FMLA also allows an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.	Same as previous column.	Same as previous column.	Employee may revoke election and make another election as provided under FMLA.	Same as previous column.
B. Employee's Return From FMLA Leave	• Employee may be reinstated in benefit elections if coverage terminated while on FMLA leave. • Employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA	Same as previous column.	Same as previous column. Upon return, employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced pro	• Employee may be reinstated in benefit if coverage terminated while on FMLA leave. • Employer may require an employee to be reinstated in his or her election upon return from	Same as previous column.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	AD&D Coverage
	leave are required to be reinstated in their elections.		rata for the missed contributions.	leave if employees who return from a non-FMLA leave are required to be reinstated in their elections.	
XII. CHANGES IN 401(k) CONTRIBUTIONS					
If employee elected to participate in a 401(k) option under the cafeteria plan, he or she may change his or her deferral amount under the 401(k) option during a plan year. Note that an employee who makes a mid-year reduction to an existing 401(k) election under a cafeteria plan may be limited to receiving the difference as taxable compensation; additional nontaxable benefits cannot be elected unless another permitted election change event has occurred that would allow the elections for these benefits to be changed.	No change permitted.	No change permitted.	No change permitted.	No change permitted.	No change permitted.