**Minutes of**
**Clay County Board of Supervisors**
**Meeting Held Monday, August 19, 2019 at 9:00 a.m.**

**BE IT REMEMBERED** a regular meeting of the Clay County Board of Supervisors was held at the Clay County Courthouse, West Point, Mississippi, on Monday, August 19, 2019.

PRESENT:

R.B. Davis, Supervisor District 3, Presiding
Lynn D. Horton, Supervisor District 1
Luke Lummus, Supervisor District 2
Shelton Deanes, Supervisor District 4
Joe Chandler, Supervisor District 5

Amy G. Berry, Clay County Chancery Clerk
Angela Turner Ford, Board Attorney
Ramirez Williams, Sheriff's Chief Deputy

Kim Brown Hood, Drug Court Coordinator
Member of News Media
County Residents

The following proceedings were had:

CALL TO ORDER/INVOCATION

The meeting was called to order by Deputy Ramirez Williams. The welcome was given by Supervisor Davis with invocation given Supervisor Deanes.

ADOPTION OF AGENDA

Motion by Supervisor Horton to adopt the agenda as prepared.

– Second by Supervisor Chandler.

(See Exhibit "A" - Agenda).

AMENDMENT OF AGENDA

Motion by Supervisor Chandler to call for amendments of the agenda.

– Second by Supervisor Horton.

AMENDMENTS TO AGENDA ANNOUNCED

Treva Hodge to be recognized to discuss the Cafeteria Plan

Supervisor Deanes requested to be recognized at the appropriate time

ADVERTISING FOR PRAIRIE ARTS FESTIVAL AND HIGH SCHOOL FOOTBALL TEAM(S)

Motion by Supervisor Deanes to authorize advertisement with the Daily Times Leader in the amounts of $200.00 for the local football teams and $150.00 for the Prairie Arts Festival.'

–Seconded by Supervisor Chandler. (Exhibit "B")

CONTINUING DISCLOSURE FILINGS BY BUTLER SNOW FOR FY 2018

Motion by Supervisor Deanes to authorize and to be spread on the minutes Butler Snow's having filed Continuing Disclosure Statements with the Securities and Exchange Commission on behalf of the County for Fiscal Year 2018.

–Seconded by Supervisor Horton.

(Exhibit "C")

LINK INVOICE

Motion by Supervisor Horton to authorize and approve LINK Invoices in the amount of $2,855.00 for special services.

–Seconded by Supervisor Chandler.

(Exhibit "D")

PURCHASE CLERK AUTHORIZATION NOT TO EXCEED $250.00 WITHOUT PRIOR APPROVAL OF SUPERVISOR DEANES

Motion by Supervisor Horton that all purchases to made by the Purchase Clerk in excess of $250.00 must be authorized by Supervisor Deanes.

–Seconded by Supervisor Chandler.

BUDGET HEARING

Motion by Supervisor Deanes to receive Intervention Court (f/k/a Drug Court) Budget, as presented by Kim Brown Hood.

–Seconded by Supervisor Horton.

(Exhibit "E")

CAFETERIA PLAN DOCUMENTS

Motion by Supervisor Horton to spread on the minutes Cafeteria Plan Documents as Glynn Griffing and Associates.

–Seconded by Supervisor Chandler.

(Exhibit "F")

CLOSED SESSION

Motion by Supervisor Deanes to go into Closed Session to determine the need to go into Executive Session.

–Seconded by Supervisor Horton.

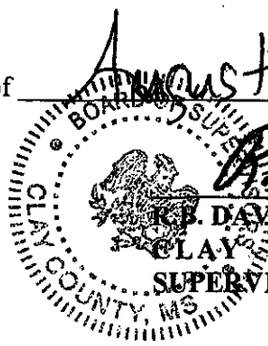
EXECUTIVE SESSION

Motion by Supervisor Horton to go into Executive Session regarding a personnel matter and a matter of potential litigation.

–Seconded by Supervisor Chandler.

* All Motions were carried unanimously unless otherwise indicated.

DATED this the 19th day of August, 2019.




R.B. Davis

**R.B. DAVIS, PRESIDENT**
**CLAY COUNTY BOARD OF SUPERVISORS**

**ATTEST:**

**AMY G. BERRY, CHANCERY CLERK**
**CLERK OF THE CLAY COUNTY**
**BOARD OF SUPERVISORS**

# EXHIBIT A

***Clay County Board of Supervisors***
***Agenda for Meeting***
***Monday, August 19, 2019 at 9:00 a.m.***

- Call to Order
- Welcome and Prayer
- Adopt and Amend Agenda
- Consider PAF and Football Advertising resources for the DTL newspaper
- Authorize and approve the Continuing Disclosure as submitted by Butler Snow FY 2018
- Authorize and approve LINK invoices for Special Services in the amount of $2,855.00
- Authorize and approve for the Purchase Clerk to not issue a purchase in excess of $ _____ without prior approval
- Kim Brown Hood
    - Drug Court Budget
- Request to go into Executive Session as allowed under Section 25-41-7, of *the Mississippi Code*, regarding a personnel matter
- Budget FY2020
- Recess until _____, August ____, 2019, at 9:00 a.m.

**Amendments:**

_____

_____

_____

_____

# EXHIBIT B

**Amy Berry**

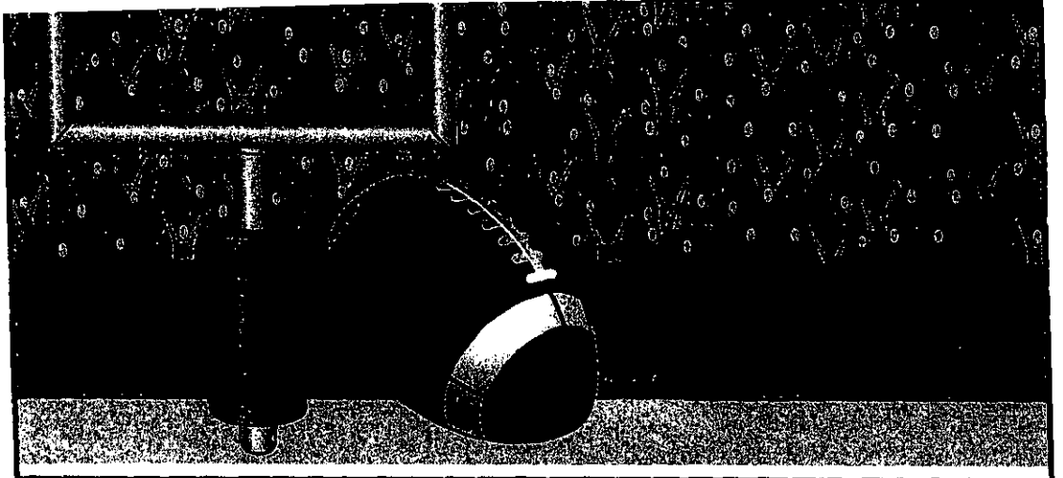
**From:** Trevor Edmondson <trevor@starkvilledailynews.com>
**Sent:** Wednesday, August 14, 2019 6:13 PM
**To:** Amy Berry
**Subject:** Daily Times Leader Football Preview
**Attachments:** Clay County Board FB18.pdf; Untitled attachment 00007.htm; Clay Co Board PAF18.pdf; Untitled attachment 00010.htm

Hello Amy,

I just wanted to check and see if the County Board of Supervisors would be interested in participating in the 2019 Football Preview and Prairie Arts Festival Special Sections again this year. Last year you all ran a half page in the Football Preview and a half page in the Prairie Arts Festival special section in the Daily Times Leader. I am going to include copies of the ads from last year that you ran in each section. If you would like to participate I can make any revisions needed for either ad. The price for the same black and white ad would be $200 for the Football Preview and $150 for the Prairie Arts Festival. Please feel free to contact me anytime if you have any questions or if I can help you with anything.

Cell: 662-769-4023

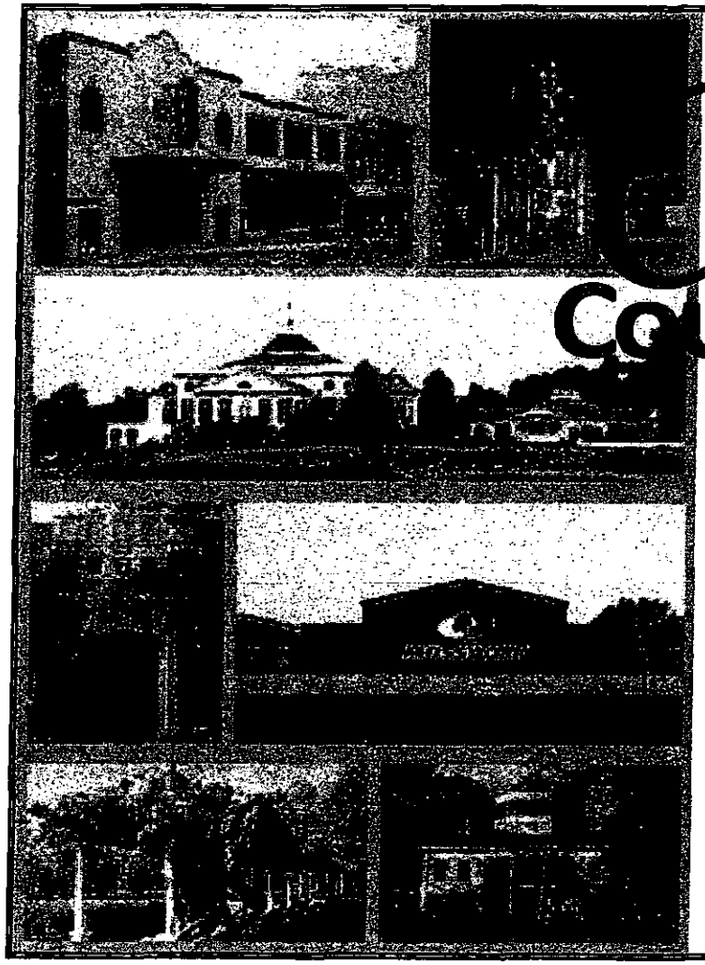
Football Preview Ad 2108:



ON BEHALF OF
CLAY COUNTY

WE WOULD LIKE
TO WISH
ALL THE TEAMS
A SUCCESSFUL
AND HEALTHY
FOOTBALL SEASON!

CLAY COUNTY
BOARD OF
SUPERVISORS



Clay County
SUPERVISORS

*We wish everyone a wonderful Labor Day Saturday at the*

# *40th Annual* Prairie Arts Festival!

**TO THE VOLUNTEERS:**
We are so proud of your efforts!
Good luck on a great festival!

# EXHIBIT C

**Amy Berry**

**From:** Pamela Wilder <Pamela.Wilder@butlersnow.com>
**Sent:** Friday, August 16, 2019 11:36 AM
**To:** aberry@claycounty.ms.gov
**Cc:** angela@bturnerlaw.com
**Subject:** FY 2018 CONTINUING DISCLOSURE SUBMISSIONS - CLAY COUNTY, MS (6 Attachments)
**Attachments:** FY 2018 Continuing Disclosure Report - Clay County, MS[ButlerSnow_48881512v1].PDF; FY 2018 Continuing Disclosure Invoice (Butler Snow) - Clay County, MS[ButlerSnow_48842061v1].PDF; FY 2018 Appendix A Information- Clay County, MS Emailing: Submission Prev... (107 KB); FY 2017 Unaudited Financial Statements - Clay County, MS Emailing: Submis... (106 KB); FY 2019 Budget - Clay County, MS Emailing: Submission Preview Print (106 KB); Notice of Failure to File FY 2018 Audit or Unaudited Financial Informatio... (107 KB)

**Importance:** High

BUTLER | SNOW

**VIA E-MAIL AT ABERRY@CLAYCOUNTY.MS.GOV**

Amy Berry, Chancery Clerk
Clay County, Mississippi
P.O. Box 815
West Point, Mississippi 39773-0815

Re: Clay County, Mississippi Fiscal Year 2018 Continuing Disclosure Submission (the "Disclosure Submission")

Dear Amy:

Attached please find copies of the County's Disclosure Submission, filed for and on behalf of the County for the fiscal year ended September 30, 2018. Please review and make sure that all of the information contained in the Disclosure Submission is correct. If there are any revisions, please e-mail the changes to pamela.wilder@butlersnow.com. Upon receipt of the revisions, we will file a supplement to the Disclosure Submission with the appropriate repository. If there are no changes, please retain a copy of the Disclosure Submission for your records. We suggest that the Disclosure Submission be spread upon the minutes of the Board at its next meeting.

Please note the following items included in the Disclosure Submission and the filing dates for each:

| FY 2018 APPENDIX A | 2019 BUDGET | NOTICE FOR 2018 AUDIT |
|---|---|---|
| 3/26/2019 | 3/18/2019 | 2/14/2019 |

*FY 2017 Unaudited financial information was filed on 3/18/19.

**In order to comply with the County's Continuing Disclosure Agreement, please send us copies of the 2017 and 2018 Audited Financial Statements for submission when the audits become available.**

I have attached our Statement of Services. Please place the Statement in line for payment at your earliest convenience and return a copy of the Statement for Services with your payment.

If you have any questions, please do not hesitate to contact us. We appreciate the opportunity to work with you again this year and look forward to working with you in the future.

Very truly yours,

BUTLER SNOW LLP

Elizabeth Lambert Clark

Elizabeth Lambert Clark

cc: Angela Turner Ford, Esq., Board Attorney (via email: angela@bturnerlaw.com)

**Pamela R. Wilder**
*Paralegal*
**Butler Snow LLP**

D: (601) 985-4335 | F: (601) 985-4500
1020 Highland Colony Parkway, Suite 1400, Ridgeland, MS 39157
P.O. Box 6010, Ridgeland, MS 39158-6010
Pamela.Wilder@butlersnow.com | vCard

Twitter | LinkedIn | Facebook | YouTube

---

**APPENDIX A - ECONOMIC AND DEMOGRAPHIC INFORMATION**

**FISCAL YEAR 2018**

**CLAY COUNTY, MS**

**APPENDIX A**
**ECONOMIC AND DEMOGRAPHIC INFORMATION**

## General Description

Clay County, Mississippi (the "County"), is located in the black prairie hills of northeast Mississippi and had its early beginnings as an agricultural and railroad town. It is also located at the top of the "Golden Triangle" which is comprised of the cities of West Point, Columbus, and Starkville. It is the northern-most point of the Golden Triangle area, with Columbus and Starkville being the southern point of the triangle. The County is located 136 miles west of Birmingham, Alabama 142 miles northeast of Jackson, Mississippi the capital city of the State of Mississippi, and 140 miles southeast of Memphis, Tennessee.

## Population

The population of the County has been recorded as follows:

| 1990 | 2000 | 2010 | 2017 Estimate |
|---|---|---|---|
| 21,151 | 21,972 | 20,558 | 20,634 |

SOURCE: Census Data at website: www.census.gov; February 2019.

## Government

The Governing Body of the County is the Board of Supervisors consisting of five supervisors, each of whom is elected from a separate district or "beat". The members of the Board of Supervisors are elected for concurrent four year terms. The current members of the Board of Supervisors are:

| Name | Occupation | Position Held Since |
|---|---|---|
| Lynn "Don" Horton | Supervisor | 2005 |
| Luke Lummus | Supervisor/Cattle Farmer/Professional Rodeo | 1996 |
| R. B. Davis | Supervisor/Business Owner | 2004 |
| Shelton L. Deanes | Supervisor | 1992 |
| Joe D. Chandler | Supervisor | 2015 |

## Transportation

US Highway 45 and State Highways 46, 47, 25 provide access to most communities within the County. A number of County highways provide access to many outlying areas in the County. Other major forms of transportation are available in the County. The Columbus and Greenville Railway and the Kansas City Southern provide rail service to the County. Commercial air transportation is available at Golden Triangle Regional Airport in Columbus, Mississippi. The Port of Clay County is located on the Tennessee-Tombigbee Waterway and provides port service.

**Per Capita Income**

| Year | County | Mississippi | United States | County as % Of U.S. |
|---|---|---|---|---|
| 2017 | $35,998 | $36,636 | $51,640 | 70% |
| 2016 | 35,076 | 35,812 | 49,831 | 70 |
| 2015 | 34,645 | 35,137 | 48,940 | 70 |
| 2014 | 34,708 | 34,633 | 47,025 | 74 |
| 2013 | 35,208 | 33,851 | 44,826 | 79 |

SOURCE: Bureau of Economic Analysis: Regional Economic Accounts at website: www.bea.gov, last updated November 15, 2018. February 2019.

**Major Employers**

The following is a partial listing of major employers in the County, their products or services and their approximate number of employees:

| Name | Approximate Number of Employees | Business Sector |
|---|---|---|
| Yokohama Tire Manufacturing | 500 | Manufacturing |
| North MS Medical Center | 320 | Healthcare |
| Royal Trucking | 185 | Transportation |
| Prestage Farms | 200 | Agricultural & Food Processing |
| Navistar Defense, LLC | 105 | Defense |
| Ellis Steel Company | 100 | Structural Metal Manufacturing |
| Mossy Oak / Haas Outdoors, Inc. | 65 | Sporting Outdoors & Athletic Good Manufacturing |
| Clay County School District | 49 | Education |
| Southern Ionics, Inc. | 35 | Inorganic Chemical Manufacturing |
| Orman Welding & Fabrication, Inc. | 22 | Metals Fabrication |
| Long Branch, Inc. | 13 | Structural Steel Fabrication |
| SIMS Metal Management MS | 20 | Metals Processing and Recycling |

SOURCE: Golden Triangle Development, March 2019.

**Unemployment Statistics of the County**

| Year | Jan. | Feb. | Mar. | Apr. | May | Jun. | Jul. | Aug. | Sep. | Oct. | Nov. | Dec. | Annual Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 | 16.6 | 14.9 | 15.0 | 14.0 | 15.1 | 17.0 | 17.3 | 15.7 | 14.9 | 15.5 | 14.7 | 14.2 | 15.5 |
| 2014 | 16.6 | 14.2 | 14.2 | 12.4 | 13.6 | 14.8 | 15.0 | 12.7 | 11.9 | 11.5 | 10.9 | 11.0 | 13.3 |
| 2015 | 11.9 | 10.1 | 9.6 | 8.6 | 10.0 | 10.8 | 10.7 | 8.8 | 8.8 | 8.5 | 8.5 | 8.5 | 9.6 |
| 2016 | 9.0 | 8.0 | 7.7 | 7.3 | 8.4 | 9.9 | 10.5 | 7.7 | 7.6 | 7.3 | 6.8 | 7.2 | 8.1 |
| 2017 | 8.1 | 6.7 | 6.6 | 5.8 | 6.7 | 7.9 | 8.6 | 6.6 | 6.1 | 6.1 | 5.9 | 5.8 | 6.8 |
| 2018 | 5.8 | 5.6 | 5.3 | 5.2 | 6.6 | 7.5 | 7.7 | 6.2 | 6.0 | 5.7 | 5.4 | 5.7 | 6.0 |

SOURCE: Mississippi Department of Employment Security: Labor Market Data at website: www.mdes.ms.gov; February 2019.

**Employment Statistics**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|
| RESIDENCE BASED EMPLOYMENT | | | | | | |
| I. Civilian Labor Force | 8,400 | 7,980 | 8,020 | 8,030 | 7,850 | 8,400 |
| II. Unemployed | 1,300 | 1,060 | 770 | 650 | 530 | 1,300 |
| Rate | 15.5 | 13.3 | 9.6 | 8.1 | 6.8 | 15.5 |
| III. Employed | 7,100 | 6,920 | 7,250 | 7,380 | 7,320 | 7,100 |
| ESTABLISHMENT BASED EMPLOYMENT | | | | | | |
| I. Manufacturing | 580 | 530 | 670 | 690 | 690 | 580 |
| II. Non-manufacturing | 4,600 | 4,670 | 4,760 | 4,790 | 4,710 | 4,600 |
| Agriculture, Forestry, Fishing & Hunting | 100 | 110 | 110 | 120 | 120 | 100 |
| Mining | 10 | 10 | 10 | 10 | 10 | 10 |
| Utilities | 20 | 20 | 20 | 10 | 10 | 20 |
| Construction | 230 | 230 | 210 | 210 | 220 | 230 |
| Wholesale Trade | 200 | 210 | 210 | 210 | 190 | 200 |
| Retail Trade | 790 | 810 | 820 | 850 | 860 | 790 |
| Transportation & Warehousing | 310 | 330 | 420 | 420 | 390 | 310 |
| Information | 30 | 30 | 30 | 20 | 20 | 30 |
| Finance & Insurance | 140 | 140 | 130 | 130 | 130 | 140 |
| Real Estate, Rental & Leasing | 30 | 30 | 30 | 40 | 50 | 30 |
| Prof., Scientific & Technical Service | 120 | 120 | 110 | 110 | 110 | 120 |
| Management of Companies & Enterprises | 130 | 130 | 130 | 130 | 140 | 130 |
| Administrative Support & Waste Management | 100 | 80 | 90 | 90 | 80 | 100 |
| Educational Services | 60 | 60 | 60 | 80 | 60 | 60 |
| Health Care & Social Assistance | 650 | 660 | 690 | 650 | 660 | 650 |
| Arts, Entertainment & Recreation | 120 | 130 | 130 | 150 | 130 | 120 |
| Accommodation & Food Service | 460 | 490 | 500 | 520 | 480 | 460 |
| Other Service (except Public Admin.) | 130 | 120 | 130 | 120 | 130 | 130 |
| Government | 970 | 960 | 930 | 920 | 920 | 970 |
| Education | 520 | 500 | 490 | 480 | 470 | 520 |
| TOTAL EMPLOYMENT | **5,180** | **5,200** | **5,430** | **5,480** | **5,400** | **5,180** |

SOURCE: Mississippi Department of Employment Security: Annual Averages: Labor Force and Establishment Based Employment 2011 Forward, Labor Market Information Department at website: www.mdes.ms.gov; February 2019.

**Retail Sales**

| State Fiscal Year Ended June 30 | Amount |
|---|---|
| 2018 | $228,363,588 |
| 2017 | 231,508,069 |
| 2016 | 231,563,586 |
| 2015 | 273,678,649 |
| 2014 | 246,672,774 |

SOURCE: Annual Reports for years shown, Mississippi Department of Revenue's website: www.dor.ms.gov; February 2019.

**Educational Facilities**

The Clay County School District (the "former District"), located in the County portion outside of the City of West Point, consisted of one (1) elementary school and employed 49 teachers and staff. Effective July 1, 2015, it was consolidated into the West Point Consolidated School District (the "District").

Enrollment for the District and the former District for the current year and the four prior years are as follows:

| Scholastic Year | District[1] |
|---|---|
| 2018-19 | 3,000 |
| 2017-18 | 3,057 |
| 2016-17 | 3,147 |
| 2015-16 | 3,270 |
| 2014-15 | 149 |

SOURCE: Office of Research and Statistics, Mississippi Department of Education website: http://reports.mde.k12.ms.us/maars/; February 2019.

[1] Prior to the 2015-16 School Year, the Clay County School District operated independently of the West Point Consolidated School District.

## TAX INFORMATION

**Assessed Valuation**[2]

| Assessment Year | Real Property | Personal Property | Public Utility Property | Total |
|---|---|---|---|---|
| 2018 | $109,246,861 | $48,658,809 | $9,105,743 | $167,011,413 |
| 2017 | 108,145,511 | 36,086,057 | 8,957,257 | 153,188,825 |
| 2016 | 105,932,573 | 36,690,120 | 9,055,298 | 151,677,991 |
| 2015 | 97,339,168 | 35,066,243 | 8,247,602 | 140,653,013 |
| 2014 | 96,113,301 | 34,158,859 | 8,003,242 | 138,275,402 |

SOURCE: Office of the County Tax Assessor; March 2019.

**Procedure for Property Assessment**

Assessed valuations are based upon the following assessment ratios:

(a) Real and personal property (excluding single-family owner-occupied residential real property and motor vehicles, respectively), fifteen percent (15%) of true value;

(b) Single-family owner-occupied residential real property, ten percent (10%) of true value;

(c) Motor vehicles and public utility property, thirty percent (30%) of true value.

The 1986 Session of the Mississippi Legislature adopted House Concurrent Resolution No. 41 (the "Resolution"), pursuant to which there was proposed an amendment to the Mississippi Constitution of 1890 (the "Amendment"). The Amendment provided, *inter alia*, that the assessment ratio of any one class of property shall not be more than three times the assessment ratio on any other class of property.

The Amendment set forth five classes of property and the assessment ratios which would be applicable thereto upon the adoption of the Amendment. The assessment ratios set forth in the Amendment are identical to those established by Section 27-35-4, Mississippi Code of 1972, as it existed prior to the Amendment, except that the assessment ratio for a single-family, owner-occupied residential real property under the Amendment is set at ten percent (10%) of true value as opposed to fifteen percent (15%) of true value under previously existing law.

**Procedure for Property Assessments**

Real and personal property valuations other than motor vehicles and property owned by public utilities are determined by the County Tax Assessor. All taxable real property situated in the County is assessed each year and taxes thereon paid for the ensuing year. Assessment rolls of such property subject to taxation are prepared by the County Tax Assessor and are delivered to the Board of Supervisors of the County on the first Monday in July. Thereafter, the assessments are equalized by the Board of Supervisors and notice is given to the taxpayers that the Board of Supervisors will meet to hear objections to the assessments. After objections are heard, the Board of

[2]The total assessed valuation is approved in September preceding the fiscal year of the County represents the value of real property, personal property and public utility property for the year indicated on which taxes are assessed for the following fiscal year's budget. For example, the taxes for the assessed valuation figures for 2018 are collected starting in January, 2019 for the 2018-19 fiscal year budget of the County.

Supervisors adjusts the rolls and submits them to the Department of Revenue, formerly known as Department of Revenue (hereafter "Department of Revenue," unless otherwise notated) which examines them on receipt. The Department of Revenue may then accept the rolls or, if it finds a roll incorrect in any particular, return the rolls to the Board of Supervisors to be corrected in accordance with the recommendations of the Department of Revenue. If the Board of Supervisors has any objections to the order of the Department of Revenue, it may arrange a hearing before the Commission. Otherwise, the assessment roll is finalized and submitted to the County Tax Collector for collection. The assessed value of motor vehicles is determined by an assessment schedule prepared each year by the Department of Revenue. With minor exceptions the property of public utilities is assessed each year by the Department of Revenue.

**Tax Levy per $1,000 Valuation**[3]

| | 2018-19 | 2017-18 | 2016-17 | 2015-16 | 2014-15 |
|---|---|---|---|---|---|
| GENERAL COUNTY | | | | | |
| Countywide – General Fund | 35.10 | 35.10 | 33.39 | 34.00 | 33.80 |
| Bridges & Culverts | 7.00 | 7.00 | 7.00 | 7.00 | 7.00 |
| Clay County School District | 0.00 | 0.00 | 0.00 | 55.00 | 55.00 |
| Tombigbee River Valley Water Management District | 0.69 | 0.69 | 0.89 | 0.74 | 0.74 |
| County Utilization Fund | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| Tombigbee River Watershed Area | 0.20 | 0.20 | 0.00 | 0.20 | 0.20 |
| East MS Community College Maintenance | 1.41 | 1.41 | 1.41 | 1.50 | 1.58 |
| Vocational Training School Maintenance | 0.77 | 0.77 | 0.76 | 0.80 | 0.89 |
| Vocational Training School Capital Outlay | 0.68 | 0.68 | 0.67 | 0.70 | 0.74 |
| East MS Community College Capital Outlay | 0.90 | 0.90 | 0.90 | 0.95 | 0.99 |
| Tombigbee Regional Library System | 0.57 | 0.57 | 0.57 | 0.60 | 0.63 |
| East MS Community College Debt Service | 0.50 | 0.62 | 0.00 | 0.00 | 0.00 |
| DHS Building Bonds 1999 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Daily Times Leader Building Renovation Notes 2011 | 0.00 | 0.00 | 0.00 | 0.30 | 0.38 |
| UNA Community Center GO Note 2017 | 0.10 | 0.12 | 0.00 | 0.00 | 0.00 |
| Daily Times Leader Building Renovation Notes 2012 | 0.00 | 0.00 | 0.07 | 0.13 | 0.00 |
| GO Acquisition & Construction Notes 2014 | 0.32 | 0.25 | 0.42 | 0.43 | 0.36 |
| Fire Protection | 0.90 | 0.91 | 1.03 | 1.08 | 1.08 |
| Supervisor District One Road Bonds 2013 | 0.60 | 0.52 | 0.70 | 0.75 | 0.25 |
| Supervisor District Two Road Bonds 2001 | 0.28 | 0.20 | 0.56 | 0.94 | 0.25 |
| Supervisor District Three Road Bonds 2000 | 0.35 | 0.27 | 1.39 | 1.16 | 0.31 |
| Supervisor District Four Road Bonds 2008 | 0.69 | 0.17 | 1.99 | 1.50 | 1.00 |
| Supervisor District Four Road Bonds UNA | 0.00 | 0.56 | 0.00 | 0.36 | 0.00 |
| Supervisor District Five Road Bonds 2000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.51 |
| Supervisor District Five Road Bonds 2013 | 0.08 | 0.00 | 1.24 | 1.54 | 1.08 |
| TOTAL | 52.14 | 51.94 | 54.48 | 110.68 | 107.79 |

SOURCE: Office of the Chancery Clerk; March 2019.

[3] Tax levy figures are given in mills. There is a 9 cents per acre of all uncultivated lands for the prevention of forest fires.

**Ad Valorem Tax Collections**

| Fiscal Year Ended September 30 | Amount Budgeted | Amount Collected | Difference Over/(Under) |
|---|---|---|---|
| 2018 | $5,828,615 | $5,939,240 | $110,625 |
| 2017 | 5,828,615 | 5,755,363 | (73,252) |
| 2016 | 5,315,552 | 5,468,966 | 153,414 |
| 2015 | 5,112,558 | 5,211,237 | 98,679 |
| 2014 | 5,074,996 | 5,162,795 | 87,799 |

SOURCE: Office of the County Tax Assessor/Collector; March 2019.

**Procedure for Tax Collections**

The Board of Supervisors is required under the Act and the Bond Resolution to levy annually a special tax upon all taxable property within the County sufficient to provide for the payment of the principal of and the interest on the Bonds. If any taxpayer neglects or refuses to pay his taxes on the due date thereof, the unpaid taxes will bear interest at the rate of 1% per month or fractional part thereof from the delinquent date to the date of payment of such taxes. When enforcement officers take action to collect delinquent taxes, other fees, penalties and costs may accrue. Both real property and personal property are subject to public tax sale.

Ad valorem taxes on personal property are payable at the same time and in the same manner as on real property. Section 27-41-15, Mississippi Code of 1972, provides that upon failure of the taxpayer to make timely payment, the tax collector of each county is authorized to sell any personal property liable for unpaid taxes at the courthouse door of the county unless the property is too cumbersome to be removed. Five days' notice of the sale in an advertisement posted in three public places in the county, one of which must be the courthouse, is required. Municipal tax collectors are required to follow any special ordinance adopted by a municipality on personal property sales. Interest, fees, costs and expenses of sale are recoverable in addition to the taxes delinquent. If sufficient personal property cannot be found, the tax collector may make a list of debts due the taxpayer by other persons and sell such debts and is further directed to distrain and sell sufficient other properties of the taxpayer to pay the delinquent taxes. Debts sold may be redeemed within six months from the sale in the same manner as redemption of land from tax sales.

Section 27-41-55, Mississippi Code of 1972, as amended, provides that after the fifth day of August in each year, the tax collector for each county shall advertise and sell all land in the county on which all taxes due and in arrears have not been paid, as well as all land liable for other matured taxes. The sale is held at the door of the courthouse of the county or any place within the courthouse that the tax collector deems suitable to hold such sale, provided that the place of such sale shall be designated by the tax collector in the advertisement of the notice of tax sale on the last Monday of August following. The owner, or any person with an interest in the land sold for taxes, may redeem the land at any time within two years after the day of sale by paying all taxes, costs, interest and damages due to the Chancery Clerk. A valid tax sale will mature two years after the date of sale unless the land is redeemed and title will vest in the purchaser on such date.

At the option of the tax collector, advertisement for the sale of such county lands may be made after the fifteenth day of February in each year with the sale of such lands to be held on the first Monday of April following. All provisions which relate to the tax sale held in August of each year shall apply to the tax sale if held in April.

County and municipal taxes, assessed upon lands or personal property, are entitled to preference over all judgments, executions, encumbrances or liens however created.

**Reappraisal of Property and Limitation on Ad Valorem Levies**

Senate Bill No. 2672, General Laws of Mississippi, Regular Session 1980, codified in part as Sections 27-35-49 and 27-35-50, Mississippi Code of 1972 (the "Reappraisal Act"), provides that all real and personal property in the State shall be appraised at true value and assessed in proportion to true value. To insure that property taxes do not increase dramatically as the counties complete reappraisals, the Reappraisal Act provides for the limit on increase in tax revenues discussed below.

The statute limits ad valorem tax levies by the County subsequent to October 1, 1980, to a rate which will result in an increase in total receipts of not greater than ten percent (10%) over the previous year's receipts, excluding revenue from ad valorem taxes on any newly constructed properties, any existing properties added to the tax rolls or any properties previously exempt which were not assessed in the next preceding year. This limitation does not apply to levies for the payment of the principal of and the interest on general obligation bonds issued by the County or to certain other specified levies. The limitation may be increased only if the proposed increase is approved by a majority of those voting in an election held on such question.

On August 20, 1980, the Mississippi Supreme Court rendered its decision in State Tax Commission v. Fondren, 387 So.2d 712, affirming the decree of the Chancery Court of the First Judicial District of Hinds County, Mississippi, wherein the State Tax Commission was enjoined from accepting and approving assessment rolls from any county in the State for the tax year 1983 unless the State Tax Commission equalized the assessment rolls of all of the counties. Due to the intervening passage of the Reappraisal Act, the Supreme Court reversed that part of the lower court's decree ordering the assessment of property at true value (although it must still be appraised at true value), holding instead that assessed value may be expressed as a percentage of true value. Pursuant to the Supreme Court modification of the Chancellor's decree, on November 15, 1980, the State Tax Commission (Department of Revenue) filed a master plan to assist counties in determining true value. On February 7, 1983, the Chancery Court granted an extension until July 1, 1984, of its previous deadline past which the State Tax Commission could not accept and approve tax rolls from counties which had not yet reappraised. The County has completed reappraisal.

**Homestead Exemption**

The Mississippi Homestead Exemption Law of 1946 reduces the local tax burden on homes qualifying by law and substitutes revenues from other sources of taxation on the State level as a reimbursement to the local taxing units for such tax loss. Provisions of the homestead exemption law determine qualification, define ownership and limit the amount of property that may come within the exemption. The exemption is not applicable to taxes levied for the payment of the Bonds, except as hereinafter noted.

Those homeowners who qualify for the homestead exemption and who have reached the age of sixty-five (65) years on or before January 1 of the year for which the exemption is claimed, service-connected, totally disabled American veterans who were honorably discharged from military service and those qualified as disabled under the federal Social Security Act are exempt from any and all ad valorem taxes on qualifying homesteads not in excess of $7,500 of assessed value thereof.

The tax loss resulting to local taxing units from properly qualified homestead exemptions is reimbursed by the Department of Revenue. Beginning with the 1984 supplemental ad valorem tax roll and for each roll thereafter, no taxing unit shall be reimbursed an amount in excess of one hundred six percent (106%) of the total net reimbursement made to such taxing unit in the next proceeding year.

**Ten Largest Taxpayers**

The ten largest taxpayers in the County for fiscal year 2018 are as follows:

| Taxpayer | Assessed Valuation | Taxes Collected |
|---|---|---|
| Yokohoma Tire Manufacturing MS LLC | $16,884,177 | $1,815,965.23* |
| Wal-Mart Real Estate Business Trust | 1,770,597 | 87,325.84 |
| Babcock & Wilcox Power Generation Group | 1,335,679 | 66,569.94 |
| Peco | 1,125,510 | 55,510.15 |
| Prestage Farms of Mississippi | 1,025,991 | 51,175.90 |
| Timberland Partners LP | 797,906 | 41,145.53 |
| Waverly Partners LP | 797,400 | 39,487.25 |
| West Point HIS LLC | 567,755 | 28,001.68 |
| Loves | 538,656 | 26,566.51 |
| Natures Golf | 441,100 | 21,843.27 |
| TOTALS: | $25,284,771 | $2,233,591.30 |

SOURCE: Office of the County Tax Assessor; March 2019.

*Taxes are fee in lieu.

**DEBT INFORMATION**

**Legal Debt Limit Statement**[4]

(As of March 2019)

| | 15% Limit | 20% Limit |
|---|---|---|
| Authorized Debt Limit (Last Completed Assessment for Taxation - $167,011,413) | $25,051,712 | $33,402,283 |
| Present Debt Subject to Debt Limits | -0- | -0- |
| Margin for Further Debt Under Debt Limits | $25,051,712 | $33,402,283 |

**Statutory Debt Limits**

The County is subject to a general statutory debt limitation under which no county in the State may incur general obligation bonded indebtedness in an amount which will exceed fifteen percent (15%) of the assessed value of all taxable property within such county according to the last completed assessment for taxation.

In computing general obligation bonded indebtedness for purposes of this fifteen percent (15%) limitation, there may be deducted all bonds or other evidences of indebtedness issued for the construction of hospitals, ports or other capital improvements payable primarily from the net revenues to be generated from such hospital, port or other capital improvements in cases where such revenue is pledged to the retirement of the indebtedness, together with the full faith and credit of such county.

However, in no case shall any county contract any indebtedness payable in whole or in part from proceeds of ad valorem taxes when added to all of the outstanding general obligation indebtedness, both bonded and floating, which shall exceed twenty percent (20%) of the assessed value of all taxable property within such county, but bonds issued for school purposes and bonds issued under Sections 57-1-1 through 57-1-51 are specifically excluded from both the fifteen percent (15%) limitation and the twenty percent (20%) limitation (but are subject to statutory limits applicable to bonds of each type, respectively). Bonds issued for washed-out or collapsed bridges apply only against the twenty percent (20%) limitation. Industrial development revenue bonds are excluded from all limitations on indebtedness, as are contract obligations subject to annual appropriations.

[4]**The Series 2013 Bonds are not included when computing the general obligation bonded indebtedness for purposes of the fifteen or twenty percent limitation pursuant to Section 57-75-37, Mississippi Code of 1972, as amended and/or supplemented from time to time.**

**Outstanding General Obligation Bonded Debt**

(As of March 31, 2019)

| Issue | Date of Issue | Outstanding Principal |
|---|---|---|
| Taxable General Obligation Industrial Development Bond[5] | 09/12/13 | $9,315,000 |
| **Total** | | **$9,315,000** |

**Outstanding General Obligation Bonded Debt of Supervisor Districts**

(As of March 31, 2019)

| Issue | Date of Issue | Outstanding Principal |
|---|---|---|
| General Obligation Road & Bridge Bonds, District 3 | 08/01/00 | $80,000 |
| General Obligation Road & Bridge Bonds, District 2 | 02/22/01 | 80,000 |
| General Obligation Road & Bridge Bonds, District 4 | 10/01/08 | 210,000 |
| General Obligation Road & Bridge Bonds, District 5 | 05/01/13 | 310,000 |
| General Obligation Road & Bridge Bonds, District 1 | 09/03/13 | 310,000 |
| **Total** | | **$990,000** |

[5] This bond, secured by the pledge of the County, was purchased by the Mississippi Development Bank from the proceeds of its $11,000,000 Mississippi Development Bank Taxable Special Obligation Bonds, Series 2013 (Clay County, Mississippi Taxable General Obligation Industrial Development Bond Project), dated September 12, 2013. **This obligation is not subject to the County's statutory debt limitations.**

**Other Debt**

(As of March 31, 2019)

| Issue | Date of Issue | Outstanding Principal |
|---|---|---|
| CAP Loan | 6/01/2007 | $ 485,845.87 |
| CAP Loan | 9/01/2011 | 416,991.33 |
| Capital Leases | Various | 929,866.39 |
| Cadence Bank - Land Acquisition Bank Note | 3/15/2016 | 18,000.00 |
| MDA Loan (EMCC) | 5/16/2017 | 950,000.00 |
| BankFirst - Community Center Bank Note | 6/30/2017 | 48,000.00 |
| Certificates of Participation (Lease Purchase), Series 2018 | 5/01/2018 | 4,015,000.00 |
| **Total** | | **$6,863,703.59** |

**Annual Debt Service Requirements**

| FY Ending, September 30 | General Obligation Debt[6] | | |
|---|---|---|---|
| | Principal | Interest | Total |
| 2019 | 575,000.00 | 506,892.00 | 1,081,892.00 |
| 2020 | 595,000.00 | 486,763.25 | 1,081,763.25 |
| 2021 | 615,000.00 | 463,805.58 | 1,078,805.58 |
| 2022 | 640,000.00 | 438,708.76 | 1,078,708.76 |
| 2023 | 670,000.00 | 412,030.61 | 1,082,030.61 |
| 2024 | 695,000.00 | 379,019.88 | 1,074,019.88 |
| 2025 | 735,000.00 | 339,172.93 | 1,074,172.93 |
| 2026 | 775,000.00 | 297,093.78 | 1,072,096.78 |
| 2027 | 815,000.00 | 252,791.43 | 1,067,791.43 |
| 2028 | 865,000.00 | 205,978.23 | 1,070,978.23 |
| 2029 | 910,000.00 | 153,437.50 | 1,063,437.50 |
| 2030 | 970,000.00 | 94,687.50 | 1,064,687.50 |
| 2031 | 1,030,000.00 | 32,187.50 | 1,062, 187.50 |
| Total | $9,890,000.00 | $4,062,568.95 | $12,891,633.95 |

[6] The Annual Debt Service includes the $11,000,000 Mississippi Development Bank Taxable Special Obligation Bonds, Series 2013 (Clay County, Mississippi Taxable General Obligation Industrial Development Bond Project), dated September 12, 2013. This obligation is not subject to the County's statutory debt limitations.

**General Obligation Bonded Debt**

| Issue | Fiscal Year Ended September 30 | | | | |
|---|---|---|---|---|---|
| | 2018 | 2017 | 2016 | 2015 | 2014 |
| General Obligation Public Improvement Bonds (09/01/99) | -0- | -0- | -0- | -0- | -0- |
| General Obligation Note (Courthouse Roof) (5/6/10) | -0- | -0- | -0- | -0- | 16,000 |
| General Obligation Note (DTL Building) (9/30/11) | -0- | -0- | -0- | -0- | 90,000 |
| General Obligation Note (DTL Building) (1/5/12) | -0- | -0- | -0- | -0- | 28,000 |
| Total | -0- | -0- | -0- | -0- | $134,000 |

**Debt Ratios**

| FY Ended September 30 | General Obligation Debt | General Obligation Debt to Assessed Value |
|---|---|---|
| 2018 | -0- | -- |
| 2017 | -0- | -- |
| 2016 | -0- | -- |
| 2015 | -0- | -- |
| 2014 | $134,000 | .096% |

**Underlying General Obligation Indebtedness**

(Information available as of March 1, 2019)

| Municipality | 2010 Population | Current Assessed[7] Valuation | General Obligation Bonded Debt | General Obligation Bonded Debt Per Capita |
|---|---|---|---|---|
| City of West Point, Mississippi | 11,277 | $94,376,865 | $5,254,000[8] | $230.55 |

| School Districts | Current Assessed Valuation[7] | Total General Obligation Bonded Debt |
|---|---|---|
| West Point Consolidated School District | $174,165,439 | -0-[9] |

[7] Source: Chancery Clerk's office, March 2019.
[8] Source: City's annual financial information "Annual Debt Service Requirements" chart as posted to EMMA on 3/29/18.
[9] Source: The FY 2017Audited Financial Statements of the District.

## EXHIBIT A

**Event Notice**

The County certifies that none of the event notices have occurred with respect to the Bonds:

(1) Principal and interest payment delinquencies;

(2) Non-payment related defaults, if material;

(3) Unscheduled draws on debt service reserves, if any, reflecting financial difficulties;

(4) Unscheduled draws on credit enhancements reflecting financial difficulties;

(5) Substitution of credit or liquidity providers, or their failure to perform;

(6) Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;

(7) Modifications to rights of Bondholders, if material;

(8) Bond calls, if material, and tender offers;

(9) Defeasances;

(10) Release, substitution, or sale of property, if any, securing repayment of the Bonds, if material;

(11) Rating changes;

(12) Bankruptcy, insolvency, receivership, or similar event of the Issuer;

(13) The consummation of a merger, consolidation, or acquisition involving the Issuer or the sale of all or substantially all of the assets of the Issuer, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and/or

(14) Appointment of a successor or additional trustee or the change of name of a trustee, if material.

**CLAY COUNTY, MISSISSIPPI**

BY: _____
President, Board of Supervisors

Dated: _____

There came before the Clay County Board of Supervisors in regular session on Thursday, September 6, 2018, the matter of adopting the budget for fiscal year 2018-2019. Upon motion by Luke Lummus and second by Shelton Deanes by unanimous vote of the Supervisors,the following budget for fiscal year 2018-2019 was adopted.

**Clay County**
**Combined Budget For Publication**
**For The Fiscal Year Ending September 30, 2019**

| | Governmental Fund Types | | | | Proprietary Fund Types | | |
|---|---|---|---|---|---|---|---|
| | General | Special Revenue | Capital Projects | Debt Service | Enterprise | Internal Service | Totals |
| **Revenues** | | | | | | | |
| Amount necessary to be raised by tax levy | $4,805,466 | $1,056,061 | $0 | $173,043 | $0 | $0 | $6,034,570 |
| Taxes and ad valorem other than tax levy | $76,000 | $7,500 | $0 | $0 | $0 | $0 | $83,500 |
| Road and Bridge privilege tax | $0 | $207,960 | $0 | $0 | $0 | $0 | $207,960 |
| License, Commissions, and Other Revenue | $278,400 | $7,900 | $0 | $0 | $0 | $0 | $286,300 |
| Fines and Forfeitures | $305,000 | $0 | $0 | $0 | $0 | $0 | $305,000 |
| Special Assessments | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Intergovernmental Revenues: | | | | | | | |
| Federal Sources | $3,900 | $0 | $0 | $0 | $0 | $0 | $3,900 |
| State Sources | $755,790 | $483,987 | $0 | $41,000 | $7,664 | $0 | $1,288,441 |
| Local Sources | $61,680 | $12,000 | $0 | $0 | $0 | $0 | $73,680 |
| Charges For Service | $351,194 | $209,100 | $0 | $0 | $300,000 | $0 | $860,294 |
| Interest Income | $21,500 | $5,080 | $0 | $0 | $500 | $0 | $27,080 |
| Miscellaneous Revenues | $60,540 | $246,000 | $0 | $0 | $1,600 | $0 | $308,140 |
| Contributions to Permanent Funds | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Financing Sources | $285,000 | $215,931 | $0 | $1,207,915 | $0 | $0 | $1,708,846 |
| Special Items | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Extraordinary Items | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Revenues** | $7,004,470 | $2,451,519 | $0 | $1,421,958 | $309,764 | $0 | $11,187,711 |
| **Beginning Cash Balance** | $1,286,058 | $3,895,124 | $0 | $42,812 | $128,720 | $0 | $5,352,714 |
| **Total Revenues and Beginning Cash Balance** | $8,290,528 | $6,346,643 | $0 | $1,464,770 | $438,484 | $0 | $16,540,425 |
| **Expenditures** | | | | | | | |
| General Government | $3,806,714 | $83,411 | $64,811 | $0 | $0 | $0 | $3,954,936 |
| Public Safety | $2,239,341 | $472,869 | $0 | $0 | $0 | $0 | $2,712,210 |
| Public Works | $0 | $1,519,521 | $0 | $0 | $282,714 | $0 | $1,802,235 |
| Health & Welfare | $158,400 | $0 | $0 | $0 | $0 | $0 | $158,400 |
| Culture & Recreation | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Education | $0 | $75,876 | $0 | $0 | $0 | $0 | $75,876 |
| Conservation of Natural Resources | $41,600 | $0 | $0 | $0 | $0 | $0 | $41,600 |
| Economic Development & Assistance | $27,304 | $0 | $0 | $0 | $0 | $0 | $27,304 |
| Debt Service | $88,793 | $348,448 | $0 | $1,461,927 | $37,486 | $0 | $1,936,654 |
| Other Expenditures | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Financing Uses | $463,800 | $173,711 | $0 | $0 | $6,000 | $0 | $643,511 |
| Special Items | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Extra Ordinary Items | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Expenditures** | $6,825,952 | $2,673,836 | $0 | $1,461,927 | $326,200 | $0 | $11,287,915 |
| **Ending Cash Balance** | $1,464,576 | $3,672,807 | $0 | $2,843 | $112,284 | $0 | $5,252,510 |
| **Total Expenditures and Ending Cash Balance** | $8,290,528 | $6,346,643 | $0 | $1,464,770 | $438,484 | $0 | $16,540,425 |

NOTICE OF FINAL ADOPTION OF 2018-2019 BUDGET FOR CLAY COUNTY, MS, Notice is hereby given to the public that the detailed copy of the adopted budget of Clay County, MS is available for public inspection upon requesting during business hours at the Courthouse in the Office of the Chancery Clerk.

Amy G. Berry
Clerk of the Board
Clay County MS

**NOTICE OF FAILURE TO FILE**
**Fiscal Year 2018 Audited or Unaudited Financial Statements**
**Clay County, Mississippi**

**NOTICE IS HEREBY PROVIDED** that the Audited Financial Statements and/or the Unaudited Financial Statements for Fiscal Year 2018 of Clay County, Mississippi are unavailable for filing at this time. The financial statements will be filed upon availability thereof. The County's most recently available unaudited financial statements for Fiscal Year 2017 were posted on March 18, 2019.

# BUTLER | SNOW

Post Office Box 6010
Ridgeland, MS 39158-6010
Main (601) 948-5711
Fax (601) 985-4500

**Client:** Clay County, Mississippi
**Matter Number:** 030539.138621
**Billing Professional:** Elizabeth Lambert Clark

**Invoice Number:** 10231882
**Invoice Date:** July 31, 2019

**DUE UPON RECEIPT**

Amy Berry, Chancery Clerk
Clay County, Mississippi
P. O. Box 815
West Point, MS 39773-0815

**Matter:** Continuing Disclosure

**Description:** Fees and expenses for services rendered for preparation and submission of Continuing Disclosure Statement for Fiscal Year 2018

**INVOICE**

For Services Rendered Through March 31, 2019

| | |
|---|---|
| **TOTAL CURRENT BILLING FOR THIS MATTER** | **$3,000.00** |

***Please reference matter and invoice number(s) with payment.***

Tax I.D. 64-0331849

**Amy Berry**

**From:** Pamela Wilder <Pamela.Wilder@butlersnow.com>
**Sent:** Tuesday, March 26, 2019 3:50 PM
**To:** Pamela Wilder
**Subject:** FY 2018 Appendix A Information- Clay County, MS Emailing: Submission Preview Print

MSRB
Municipal Securities Rulemaking Board

Print Close

**Submission ID:ER932809**
**03/26/2019 16:49:08**

## CONTINUING DISCLOSURE (Submission Status: Published)

## FINANCIAL/OPERATING FILING (CUSIP-9 Based)

**Rule 15c2-12 Disclosure**

Annual Financial Information and Operating Data: FY 2018 Appendix A Information- Clay County, MS, for the year ended 09/30/2018

## Documents

**Financial Operating Filing** Options
FY 2018 Appendix A Information - Clay County, MS .pdf posted 03/26/2019 Options

## The following issuers are associated with this continuing disclosure submission:

| CUSIP-6 | State | Issuer Name |
|---|---|---|
| 183450 | MS | CLAY CNTY MISS |
| 183454 | MS | CLAY CNTY MISS CTFS PARTN |
| 183467 | MS | CLAY CNTY MISS SUPERVISORS DIST NO 5 |
| 18346P | MS | CLAY CNTY MISS SUPERVISORS DIST NO 4 |

| 60534T | MS | MISSISSIPPI DEV BK SPL OBLIG |
|---|---|---|

**The following 75 securities have been published with this continuing disclosure submission:**

| CUSIP-9 | Maturity Date |
|---|---|
| 183450AR6 | 09/01/2000 |
| 183450AS4 | 09/01/2001 |
| 183450AT2 | 09/01/2002 |
| 183450AU9 | 09/01/2003 |
| 183450AV7 | 09/01/2004 |
| 183450AW5 | 09/01/2005 |
| 183450AX3 | 09/01/2006 |
| 183450AY1 | 09/01/2007 |
| 183450AZ8 | 09/01/2008 |
| 183450BA2 | 09/01/2009 |
| 183450BB0 | 09/01/2010 |
| 183450BC8 | 09/01/2011 |
| 183450BD6 | 09/01/2012 |
| 183450BE4 | 09/01/2013 |
| 183450BF1 | 09/01/2014 |
| 183450BG9 | 06/01/2002 |
| 183450BH7 | 06/01/2003 |
| 183450BJ3 | 06/01/2004 |
| 183450BK0 | 06/01/2005 |
| 183450BL8 | 06/01/2006 |
| 183450BM6 | 06/01/2007 |
| 183450BN4 | 06/01/2008 |
| 183450BP9 | 06/01/2009 |
| 183450BQ7 | 06/01/2010 |
| 183450BR5 | 06/01/2011 |
| 183454AA5 | 05/01/2021 |
| 183454AB3 | 05/01/2022 |
| 183454AC1 | 05/01/2023 |
| 183454AD9 | 05/01/2024 |
| 183454AE7 | 05/01/2025 |
| 183454AF4 | 05/01/2026 |
| 183454AG2 | 05/01/2027 |
| 183454AH0 | 05/01/2028 |
| 183454AJ6 | 05/01/2029 |
| 183454AK3 | 05/01/2030 |
| 183454AL1 | 05/01/2033 |
| 183454AM9 | 05/01/2038 |

| | |
|---|---|
| 183467AB5 | 10/01/2001 |
| 183467AC3 | 10/01/2002 |
| 183467AD1 | 10/01/2003 |
| 183467AE9 | 10/01/2004 |
| 183467AF6 | 10/01/2005 |
| 183467AG4 | 10/01/2006 |
| 183467AH2 | 10/01/2007 |
| 183467AJ8 | 10/01/2008 |
| 183467AK5 | 10/01/2009 |
| 183467AL3 | 10/01/2010 |
| 183467AM1 | 10/01/2011 |
| 183467AN9 | 10/01/2012 |
| 183467AP4 | 10/01/2013 |
| 183467AQ2 | 10/01/2014 |
| 183467AR0 | 10/01/2015 |
| 18346PAA7 | 12/01/2001 |
| 18346PAB5 | 12/01/2002 |
| 18346PAC3 | 12/01/2003 |
| 18346PAD1 | 12/01/2004 |
| 18346PAE9 | 12/01/2005 |
| 18346PAF6 | 12/01/2006 |
| 18346PAG4 | 12/01/2007 |
| 18346PAH2 | 12/01/2008 |
| 18346PAJ8 | 12/01/2009 |
| 18346PAK5 | 12/01/2010 |
| 18346PAL3 | 12/01/2011 |
| 18346PAM1 | 12/01/2012 |
| 18346PAN9 | 12/01/2013 |
| 18346PAP4 | 12/01/2014 |
| 18346PAQ2 | 12/01/2015 |
| 60534TRN7 | 03/01/2017 |
| 60534TRP2 | 03/01/2018 |
| 60534TRQ0 | 03/01/2019 |
| 60534TRR8 | 03/01/2020 |
| 60534TRS6 | 03/01/2021 |
| 60534TRT4 | 03/01/2023 |
| 60534TRU1 | 03/01/2028 |
| 60534TRV9 | 03/01/2031 |

**Submitter's Contact Information**

**Company:** Butler Snow LLP
**Name:** PAMELA WILDER
**Address:** P. O. BOX 6010
**City, State Zip:** RIDGELAND, MS 39158
**Phone Number:** 6019854335
**Email:** pamela.wilder@butlersnow.com

# EXHIBIT D

# Invoice

| Date | Invoice # |
|---|---|
| 8/15/2019 | 255993 |

Golden Triangle Development LINK
PO Box 1328
Columbus, MS 39703

Bill To

Clay County Board of Supervisors
PO Box 815
West Point, MS 39773

| Item Code | Description | Amount |
|---|---|---|
| Clay County Reimbursement | Jones Walker LLP 933102 | 807.50 |

Dues and Trust fees to Golden Triangle Development Link may be deductible as a necessary business expense for income tax purposes. However, the portion of your dues and Trust fees used to fund lobbying activates is not deductible. For the year, that portion is 10%. The Link's dues and Trust fees are not deductible as charitable contribution.

**Total** $807.50

**JONES WALKER LLP**
Alabama, Arizona, District of Columbia, Florida
Georgia, Louisiana, Mississippi, New York, Texas

FED. I.D.# 72-0445111

VIA EMAIL: JPRIDMORE@GTRLINK.ORG

JULY 31, 2019
INVOICE NO. 993102

RE: GENERAL PROJECT ADVICE - CLAY COUNTY

FILE NO. 140681-02

FOR PROFESSIONAL SERVICES RENDERED:

| DATE | INIT | ACTION | | HOURS |
|---|---|---|---|---|
| 06/12/19 | CSP | TELEPHONE CONFERENCE WITH J. HIGGINS RE MEETING WITH YOKOHAMA EXECUTIVES RE FUTURE OF WEST POINT PLANT | .30 | 127.50 |
| 06/18/19 | CSP | TELEPHONE CONFERENCE WITH J. HIGGINS RE NATURE'S GOLF PROJECT AND STATUS OF TOURISM REBATE APPLICATION AND REBATE PAYMENTS FOR SAME; ADVISE SAME VIA EMAIL OF PROGRAM APPLICATION, CERTIFICATION AND REBATE DISBURSEMENT REQUIREMENTS; LEFT VOICEMAIL FOR S. WATSON AT MDA RE STATUS OF SAME; LOCATE OLD EMAILS IN WHICH WE PROVIDED NATURE'S GOLF ATTORNEY WITH ALL INFORMATION AND CITY'S RESOLUTION APPROVING REBATE FOR PROJECT AS NECESSARY FOR SAME TO SUBMIT APPLICATION FOR REBATE TO THE MDA. | .70 | 297.50 |
| 06/19/19 | CSP | MULTIPLE EMAILS WITH R. JONES WITH THE CITY OF WEST POINT TO FORWARD TO SAME COPIES OF THE RESOLUTIONS APPROVED BY THE CITY IN CONNECTION WITH NATURE'S GOLF PROJECT; TELEPHONE CONFERENCE WITH S. WATSON AT MDA; CONFIRM THAT TOURISM REBATE APPLICATION WAS APPROVED AND FIRST REBATE PAYMENT SHOULD BE MAILED TO NATURE'S GOLF THIS YEAR; ADVISE J. HIGGINS RE SAME. | .40 | 170.00 |

| | | | | |
|---|---|---|---|---|
| /25/19 | CSP | CORRESPONDENCE WITH R. ROGERS AND B. BRASHER RE FINAL SURVEY OF NEW HIPPO SITE IN INDUSTRIAL PARK. | .20 | 85.00 |
| /27/19 | CSP | TELEPHONE CONFERENCE WITH G. BRYANT IN REPLY TO CALL FROM SAME ABOUT TIF BONDS AND TOURISM REBATE PROGRAM FOR NATURE'S GOLF. | .30 | 127.50 |

TOTAL HOURS: 1.90

TOTAL FEES: $807.50

TIME AND FEE SUMMARY

| TIMEKEEPER | RATE | HOURS | FEES |
|---|---|---|---|
| CHRISTOPHER S. PACE | 425.00 | 1.90 | 807.50 |
| TOTALS | | 1.90 | 807.50 |

TOTAL COSTS: $0.00

TOTAL FEES AND COSTS: $807.50

FILE NAME: GENERAL PROJECT ADVICE - CLAY COUNTY

* * * R E M I T T A N C E C O P Y * * *

| | |
|---|---|
| TOTAL FEES: | $807.50 |
| TOTAL COSTS: | $0.00 |
| LESS CREDITS: | $0.00 |
| TOTAL CURRENT FEES AND COSTS DUE | $807.50 |

BALANCE DUE ON PRIOR INVOICES:

| DATE | INVOICE NO. | BALANCE |
|---|---|---|
| 09/27/18 | 953974 | $2679.50 |
| 04/30/19 | 981259 | $850.00 |

| | |
|---|---|
| TOTAL PRIOR INVOICES DUE: | $3,529.50 |
| TOTAL AMOUNT DUE: | $4,337.00 |

PLEASE SEND PAYMENT AND REMITTANCE COPY TO:

**JONES WALKER LLP**
**201 St. Charles Ave. - 50th Floor**
**New Orleans, Louisiana 70170-5100**

' YOU PREFER TO REMIT VIA WIRE TRANSFER OR ACH CREDIT, OUR BANKING

ISTRUCTIONS ARE:

Iberia Bank
New Orleans, Louisiana
ABA Number: 265270413
Account Number: 20000247731
Account Name: Jones Walker LLP

LEASE INCLUDE OUR INVOICE NUMBER(S) IN THE WIRE OR ACH TEXT OR E-MAIL

PPLICATION INSTRUCTIONS TO JWAR@JONESWALKER.COM

E TRUST THAT YOU HAVE BEEN PLEASED WITH OUR LEGAL REPRESENTATION AND WE
PPRECIATE THE OPPORTUNITY TO REPRESENT YOU IN THESE MATTERS. IF YOU HAVE
NY QUESTIONS ABOUT THIS INVOICE, PLEASE CONTACT CHRISTOPHER S. PACE
N JACKSON OR OUR CREDIT MANAGER AT (504)582-8220.

ATLANTA, GA (404)870-7500
BATON ROUGE, LA (225)248-2000
BIRMINGHAM, AL (205)244-5200
HOUSTON, TX (713)437-1800
JACKSON, MS (601)949-4900
LAFAYETTE, LA (337)593-7600
MIAMI, FL (305)679-5700
MOBILE, AL (251)432-1414
NEW ORLEANS, LA (504)582-8000
NEW YORK, NY (646)512-8101
PHOENIX, AZ (602)366-7889
TALLAHASSEE, FL (850)425-7800
WASHINGTON, DC (CAPITOL HILL) (202)203-1000
WASHINGTON, DC (DOWNTOWN) (202)434-4660
THE WOODLANDS, TX (281)296-4400

**********

# Invoice

| Date | Invoice # |
|---|---|
| 8/8/2019 | 255992 |

Golden Triangle
Development
LINK
PO Box 1328
Columbus, MS 39703

| Bill To |
|---|
| Clay County Board of Supervisors<br>PO Box 815<br>West Point, MS 39773 |

| Item Code | Description | Amount |
|---|---|---|
| Clay County Reimbursement | Headwaters 121919 | 2,047.50 |

Dues and Trust fees to Golden Triangle Development Link may be deductible as a necessary business expense for income tax purposes. However, the portion of your dues and Trust fees used to fund lobbying activates is not deductible. For the year, that portion is 10%. The Link's dues and Trust fees are not deductible as charitable contribution.

| Total | $2,047.50 |
|---|---|

**Headwaters, Inc.**
P.O. Box 2836
Ridgeland, MS 39158
Tel: 601-634-0097 Fax: 769-233-2563
deanna@headwaters-inc.com
www.headwaters-inc.com

# Invoice

Ms. Jennifer Pridmore
Golden Triangle Development LINK
P.O. Box 1328
Columbus, MS 39703

**Invoice Date:** Apr 9, 2019
**Invoice Num:** 121919
**Billing Through:** Mar 31, 2019

**Prairie Bell Powersite West (2019-0082:) - Managed by (JWD)**

**Professional Services:**

| Date | Employee | Description | Hours | Rate | Amount |
|---|---|---|---|---|---|
| 3/19/2019 | JWD | Wetland Delineation & Determination<br>*Review site aerial photography.* | 0.50 | $150.00 | $75.00 |
| 3/21/2019 | JWD | Wetland Delineation & Determination<br>*Review GIS files of the site.* | 0.50 | $150.00 | $75.00 |
| 3/22/2019 | JWD | Wetland Delineation & Determination<br>*Review environmental files.* | 0.75 | $150.00 | $112.50 |
| 3/26/2019 | PGH | Wetland Delineation & Determination<br>*Prepare lidar map exhibit.* | 0.50 | $80.00 | $40.00 |
| 3/26/2019 | JWD | Wetland Delineation & Determination<br>*GIS due diligence review.* | 2.00 | $150.00 | $300.00 |
| 3/27/2019 | PGH | Wetland Delineation & Determination<br>*Revise map exhibit.* | 0.25 | $80.00 | $20.00 |
| 3/27/2019 | JWD | Wetland Delineation & Determination<br>*Due diligence/site reviews prior to project meeting.* | 1.50 | $150.00 | $225.00 |
| 3/28/2019 | JWD | Wetland Delineation & Determination<br>*Project meeting with the LINK team regarding Project Trident and Trinity.* | 8.00 | $150.00 | $1,200.00 |

**Total Service Amount:** $2,047.50

**Amount Due This Invoice:** $2,047.50

*This invoice is due on 5/9/2019*

Code 612

Approval _____

Approval _____

# EXHIBIT E

SUPREME COURT OF MISSISSIPPI
ADMINISTRATIVE OFFICE OF COURTS
POST OFFICE BOX 117
JACKSON, MISSISSIPPI 39205
TELEPHONE (601) 576-4630
FAX (601) 576-4639

July 18, 2019

Hon. Lee Howard
16th Circuit Judicial District Intervention Court
Post Office Box 1420
West Point, MS 39773

Dear Judge Howard:

The Administrative Office of Courts has received and reviewed your proposed budget. In accordance with the Mississippi Intervention Court Rules, the Sixteenth Circuit Judicial District Intervention Court qualifies for reimbursement not to exceed $100,000 for the period of July 1, 2019 to June 30, 2020.

Compliance with the Mississippi Intervention Court Rules, in addition to the Alyce Griffin Intervention Court Act, Miss. Code Ann. §§ 9-23-1 et seq., is required to continue to receive reimbursement from the Administrative Office of Courts.

Sincerely,

Kevin Lackey, Director
Administrative Office of Courts

cc: Lisa Counts, Deputy Director, AOC
Carol Allgood, Finance Director, AOC
Permanent File

# SUPREME COURT OF MISSISSIPPI
## Administrative Office of Courts
## Drug Court Budget Request Form – FY 2020

| *AOC USE ONLY* | |
|---|---|
| AOC Budget Requested _____ | Participant Level _____ |
| Reviewed by: _____ | Date _____ |
| AOC $$ Approved _____ | TOTAL $$ Approved _____ |
| Approved by: _____ | Date _____ |

Complete and return the budget request form along with supporting budget narrative & copies of contracts no later than May 1, 2019, to the Administrative Office of Courts (AOC). The budget request shall reflect anticipated spending from July 1, 2019, through June 30, 2020. All funding sources shall be included. Documents can be mailed or emailed by the May 1st deadline.
Email: drugcourts@courts.ms.gov or Mail: AOC, Attn: Drug Court Financial Analyst, P.O. Box 117, Jackson, MS 39205-0117.
*For questions or more information regarding this form, contact the AOC at 601.359.6567 or by the email listed above.*

Drug Court: 16th circuit Drug Court  Lead County: Clay  Phone: 662-295-7873

Remittance Address: P.O. Box 1420, West Point, MS 39773  Email: khood@claycounty.ms.gov

| Category | AOC State Reimbursable Amounts | Local Drug Court Fund Amounts | Local Government Contribution Amounts | Grant Amount _____ (name) | Grant Amount _____ (name) | Other Source _____ (name) | Other Source _____ (name) | Private Foundation / Donation Amounts | TOTAL FY 2020 BUDGET |
|---|---|---|---|---|---|---|---|---|---|
| Salaries & Fringe | $ 100,000.00 | $ 15,001.64 | | | | | | | $ 115,001.64 |
| Treatment Expenses | | | | | | | | | $ 0.00 |
| Testing & Lab Expenses | | $ 23,777.52 | | | | | | | $ 23,777.52 |
| Travel & Training | | $ 2,170.00 | | | | | | | $ 2,170.00 |
| Commodities | | $ 4,055.00 | | | | | | | $ 4,055.00 |
| Contractual Services | | $ 2,631.28 | | | | | | | $ 2,631.28 |
| Equipment | | $ 2,000.00 | | | | | | | $ 2,000.00 |
| TOTAL | $ 100,000.00 | $ 49,635.44 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 149,635.44 |

*Budget Request Prepared By:*

Signature | Kimberly B Hood (Printed Name) | Drug Court Administrator (Title) | 06/21/2019 (Date)

*Budget Request Reviewed By:*

Signature of Drug Court Judge / Referee | Lee J Howard (Printed Name of Drug Court Judge / Referee) | 06/21/2019 (Date)

# 16th Circuit Drug Court
# FY 2020 Budget Detail

Salaries & Fringe

| Name/Position | Computation | Costs |
|---|---|---|
| Kimberly Hood, Coordinator | $48,500.00 salary x 100% time x 1 year | $48,500.00 |
| Kimberly Hood, Coordinator | $48,500.00 salary x 100% time x 27.85% fringe | $22,381.17 |
| Christie Morris, P/T Case Mgr | $27,100.00 salary x 100% time x 1 year | $21,700.00 |
| Christie Morris, P/T Case Mgr | $27,100.00 salary x 100% time x 27.85% fringe | $ 17,020.47 |
| | **Salary and Fringe Total** | **$115,001.64** |

Testing & Laboratory Expenses

| Item Description | Computation | Costs |
|---|---|---|
| Instant Urine Drug Test Kits | $4.80 per test x 4700 tests x 1 year | $22,560.00 |
| Gloves | $101.59/case x 8 cases a year | $ 812.72 |
| Freight for gloves and kits | | $ 404.80 |
| | **Testing & Laboratory Total** | **$23,777.52** |

Travel & Training

| Purpose of Travel | Computation | Costs |
|---|---|---|
| Training | $104.00 per night hotel x 3 nights x 3 staff | $ 936.00 |
| | 500 miles x $0.58/mile (Case Manager) | $ 290.00 |
| | Meals @ $41 per day x 3 days x 3 staff | $ 369.00 |
| | Registration Rate $175 x 3 | $ 575.00 |
| | **Travel & Training Total** | **$ 2,170.00** |

Commodities

| Item | Computation | Costs |
|---|---|---|
| Office Supplies | $50.00/month x 12 months | $ 600.00 |
| Food/Food Supplies | $250.00 per graduation x 3 graduations | $ 750.00 |
| Fuel for Drug Court Vehicle | $40.00/wk x 52 wks | $ 2,080.00 |
| Vehicle Needs | $625.00 tires, misc. service | $ 625.00 |
| | **Commodities Total** | **$ 4,055.00** |

Contractual Services

| Item | Computation | Costs |
|---|---|---|
| Cell Phone | $51.00/mo x 1 phone x 12 months | $ 612.00 |
| Internet | $34.19/mo x 12 months | $ 410.28 |
| Office Phone/Fax | $70.00/mo x 12 months | $ 840.00 |
| Vehicle Oil Changes | $50 x 6 times per year | $ 300.00 |
| Copier Lease | $325.00 per year | $ 325.00 |
| P.O. Box Rental | $144.00 per year | $ 144.00 |
| | **Contractual Service Total** | **$ 2,631.28** |

Equipment

| Item | Computation | Costs |
|---|---|---|
| (1) desktop | $ 750.00 | $ 750.00 |
| (1) laptop | $1,000.00 | $ 1,000.00 |
| (1) printer | $ 250.00 | $ 250.00 |
| | **Equipment Total** | **$ 2,000.00** |

# EXHIBIT F

**BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement ("Agreement") is entered into by and between the Clay County Board of Supervisors (the "Sponsor") on behalf of itself and its group health plans (collectively, the "Plan") and Glynn Griffing & Associates ("Business Associate"), and is effective as of July 1, 2019 (the "Effective Date"). Collectively, the Business Associate, the Sponsor, and the Plan shall be referred to as "Party" or "Parties."

1. Purpose. Business Associate has been retained to perform services for the Plan (the "Engagement"). The Engagement requires Business Associate to be provided with, to have access to, to create, to maintain, and/or to transmit Protected Health Information ("PHI"), as clarified by the Genetic Information Nondiscrimination Act of 2008 ("GINA"), that is subject to the Health Insurance Portability and Accountability Act, 42 U.S.C. §1320d ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act of 2009, 42 U.S.C. §17901 ("HITECH"), and the federal privacy and security regulations issued pursuant to HIPAA and HITECH and codified at Title 45 Parts 160 and 164 of the Code of Federal Regulations, as may be amended from time to time. HIPAA, HITECH, and the regulations issued thereunder from time to time are collectively referred to herein as the "Rules." The Plan hereby acknowledges that it is a Covered Entity and Business Associate acknowledges that it is a Business Associate of the Plan.

2. Definitions.

   (i) Catch-all definition: Unless otherwise defined in this Agreement, all capitalized terms used in this Agreement have the meanings ascribed to them in the Rules.

   (ii) Specific definitions:

   (a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Glynn Griffing & Associates.

   (b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Plan.

   (c) Rules. The "Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, as well as HITECH.

3. Obligations and Duties of Business Associate Regarding PHI. Business Associate shall:

   (i) Not Use or Disclose PHI other than as permitted or required by the Agreement or as Required by law;

   (ii) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent Use or Disclosure of PHI other than as provided for by the Agreement;

   (iii) Report to Plan any Use or Disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of Unsecured PHI as required at 45 CFR 164.410, and any Security Incident of which it becomes aware;

   (iv) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

   (v) Make available PHI in a Designated Record Set to the Plan as necessary to satisfy Plan's obligations under 45 CFR 164.524;

   (vi) Make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the Plan pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Plan's obligations under 45 CFR 164.526. If Business Associate receives a request for amendment

to PHI directly from an individual, Business Associate shall notify the Plan within ten (10) business days after receipt of such request;

(vii) Maintain and make available the information required to provide an accounting of Disclosures to the Plan as necessary to satisfy Plan's obligations under 45 CFR 164.528. If Business Associate receives a request for amendment to PHI directly from an individual, Business Associate shall notify the Plan within ten (10) business days after receipt of such request;

(viii) To the extent the Business Associate is to carry out one or more of covered Plan's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(ix) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the Rules.

(x) Not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 13405(d) of HITECH applies.

(xi) Not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 CFR 164.501 unless permitted by HITECH.

(xii) Not Use or Disclose genetic information for underwriting purposes, as that term is defined in 45 CFR 164.502.

(xiii) Use best efforts to mitigate any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate or its Subcontractors in violation of the requirements of this Agreement;

(xiv) Comply with all application provisions of the Rules in the event that Business Associate transmits or receives any Transactions on behalf to the Plan and ensure that Subcontractors, if any, that assist Business Associate in conducting Transactions on behalf of the Plan agree in writing to comply with the Rules.

4. Permitted Uses and Disclosures by Business Associate. Except as otherwise specified in this Agreement, Business Associate may:

(i) Use and Disclose the PHI as reasonably necessary to perform its obligations under the Engagement, provided that such Use or Disclosure would not violate the Rules if done by the Plan or the minimum necessary policies and procedures of the Plan required by 45 CFR 164.514(d);

(ii) Use the PHI in its possession for Business Associate's proper management and administration and to carry out its legal responsibilities;

(iii) Disclose the PHI in its possession to a third party for the purpose of Business Associate's proper management and administration or to carry out its legal responsibilities, provided that: (i) the Disclosures are Required By Law; or (ii) Business Associate obtains reasonable assurances from the third party, in writing, that the PHI will be held confidentially and used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the third party, and the third party agrees to notify Business Associate of any instances of which it becomes aware in which the confidentiality of the PHI has been breached; and

(iv) If the Engagement includes Business Associate's provision of data aggregation services to the Plan as permitted by 45 CFR 164.504(e)(2)(i)(B), Business Associate may use and aggregate the PHI for purposes of providing such services to the Plan.

5. Plan's Obligations. The Plan agrees:

(i) To notify Business Associate of any limitation(s) in its notice of privacy practices of the Plan in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's Use or Disclosure of PHI.

(ii) To notify Business Associate of any changes in, or revocation of, permission by an Individual to Use or Disclose PHI to the extent that such changes may affect Business Associate's Use or Disclosure of PHI.

(iii) To notify Business Associate of any restriction to the Use or Disclosure of PHI that the Plan has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's Use or Disclosure of PHI.

(iv) Not to request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the Rules if done by the Plan, provided that Business Associate may Use or Disclose PHI for its proper management and administrative activities and, to the extent permitted by the Engagement, for Business Associate's Data Aggregation activities.

6. Term and Termination.

(i) This Agreement shall continue to be in effect until the Engagement terminates or expires and all PHI obtained from the Plan, or created or obtained by Business Associate on behalf of the Plan, is returned to the Plan or destroyed in accordance with the Rules, or, if Business Associate determines it is infeasible to return or destroy the PHI, protections are extended to such information in accordance with Section 6(iii) of this Agreement.

(ii) Upon either Party's knowledge of a material breach by the other party, the non-breaching party shall either:

(a) Provide an opportunity for the breaching Party to cure the breach or end the violation and terminate this Agreement and the Engagement if the breaching Party does not cure the breach or end the violation within a reasonable time specified by the non-breaching party, or

(b) Immediately terminate this Agreement and the Engagement if the breaching Party has breached a material term of this Agreement and cure is not possible.

(iii) Except as provided Section 6(iv), upon any termination or expiration of this Agreement, Business Associate shall return or destroy all PHI received from the Plan, or created or received by Business Associate on behalf of the Plan. This provision shall apply to PHI that is in the possession of subcontractors, vendors, or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its agents, subcontractors or vendors return or destroy any of Plan's PHI received from Business Associate.

(iv) If the Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

(i) A reference in this Agreement to a section in the Rules means the section as in effect or as amended. Any ambiguity in this Agreement shall be resolved to permit the Plan to comply with the Rules. The terms of this Agreement shall prevail in the case of any conflict in such terms with the terms of the Engagement, to the extent necessary to allow the Plan to comply with the Rules.

(ii) Nothing in this Agreement shall confer any rights, remedies, obligations, or liabilities whatsoever upon any person or entity other than the parties hereto and their respective successors or assigns.

(iii) This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

(iv) Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.

(v) This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

(vi) This Agreement shall be governed by the laws of the State of Mississippi (excluding the choice of law rules thereof).

IN WITNESS WHEREOF, each of the undersigned parties has caused this Agreement to be executed in its name and on its behalf by its duly authorized representative.

**BUSINESS ASSOCIATE**

By: _____

Print Name: Kim Porter

Print Title: President

Date: August 14, 2019

**EMPLOYER/PLAN**

By: _____

Print Name: Keith B. Davis

Print Title: President

Date: 8/19/2019

# Clay County Board of Supervisors
## CAFETERIA PLAN

**This Document is effective 07/01/2019.**

## TABLE OF CONTENTS

# PREAMBLE

Effective as of the date set forth below, the Clay County Board of Supervisors established the Cafeteria Plan (the "Plan" or "Cafeteria Plan") for its Employees 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.

**Clay County Board of Supervisors**
**Cafeteria Plan**

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

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

**1.06** **"Change in Status"** means any of the events described in the Summary Plan Description, 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 for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

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

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

**1.09** **"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). For purposes of Dependent Care FSA (if offered under the 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).

**1.10** **"Effective Date"** of the Plan means 07/01/2019. 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.

**1.11** **"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.

**1.12** **"Employer"** means the Clay County Board of Supervisors and 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 third party administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only Clay County Board of Supervisors. 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.

**1.13** **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

**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** **"Nonelective 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 nondiscriminatory 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 material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Package Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment material. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment material.

**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, 119, 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 "Summary Plan Description" or "SPD"** means the Flexible Benefits Plan SPD 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 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 shall be eligible to participate in this Plan as of the Eligibility Date set forth in the SPD. 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.

**2.03 Qualifying Leave Under Family Leave Act.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and 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 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 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. 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 III
## PREMIUM ELECTIONS

Salary Reductions made with respect to the Plan for a Plan Year for Health Care Reimbursement (under all Health Flexible Spending Accounts) shall not exceed $2,500 per Participant (as adjusted for inflation pursuant to Code section 125(i)) or such lower amount as set forth in the Plan SPD or Plan enrollment materials. In the event of a short Plan Year for all Participants, the $2500 amount (as indexed) shall be pro-rated.

**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 material) 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 material, may allow the Participants to allocate his allotted share of Nonelective Contributions among the various Benefit Package Options in a manner set forth in the SPD or enrollment material.

**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 third party 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 third party administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. 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 material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

**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 Nonelective Contributions except under the circumstances set forth in the SPD 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 and Medical Leave Act. Except as provided in the SPD 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 (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

**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.

## 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 Nonelective 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 Nonelective 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 Nonelective 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.

**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 Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

## ARTICLE VI
## PLAN ADMINISTRATION

**6.01 Allocation of Authority.** The Board of Directors 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 a third-party administrator and shall be identified in the SPD;

(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 Third-Party Plan Service Providers.** The Plan Administrator, subject to approval of the Employer, may employ the services of such 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 as a third-party administrator. 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 losses 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. The Plan's claim review procedures set forth in the SPD 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 Directors 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.

**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 Mississippi 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 fiduciary capacity with respect to the Plan.

**9.05 Tax Effects.** Neither the Employer, nor the Plan 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 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 SPD for this Plan contains 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 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 Cafeteria Plan as of the date set forth below.

**Clay County Board of Supervisors**

By: _____

Title: President

Date: 8.13.2019

# HEALTH FLEXIBLE SPENDING ACCOUNT

APPENDIX A TO THE
CLAY COUNTY BOARD OF SUPERVISORS
Cafeteria Plan

The Effective Date of this Document is 07/01/2019.

## TABLE OF CONTENTS

## PREAMBLE

Effective as of the date set forth below, the Clay County Board of Supervisors established this Health Flexible Spending Account (the Health FSA) to help provide full and complete medical care 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 contribute to a Health Care Reimbursement Account established pursuant to this Health FSA Plan. This Health FSA is intended to provide reimbursement of certain Eligible Medical Expenses incurred by the Participant and his eligible Dependents. The Employer intends that the Health FSA qualify as a Code Section 105 self-insured medical reimbursement plan, and that the benefits provided under the Health FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code. This Health FSA is a component of, and incorporated by reference into, the Cafeteria Plan, and Articles VI, VII, VIII and IX of the Cafeteria Plan document apply also to this Health FSA.

## ARTICLE IA
## DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix A have the same meaning as the defined terms in the 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 07/01/2019.

**1.03A "Eligible Medical Expenses"** means those expenses that are eligible for reimbursement under this Health FSA as set forth in the SPD.

**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 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.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Health FSA as of the Health FSA Eligibility Date set forth in the SPD.

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

**2.03A Qualifying Leave Under Family Leave Act.** Notwithstanding any provision to the contrary in this Health FSA, if a Participant goes on a qualifying leave under the Family and 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 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, 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 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 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 as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party 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 third party administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Health FSA as set forth in the SPD (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 or who is eligible to become a Participant in this Health FSA shall be notified, prior to each Anniversary Date of this Health FSA, of his right to become a Participant in this Health FSA, to continue participation in this Health FSA, or to modify or to cease participation in this Health 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 material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

**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, 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 and Medical Leave Act. Except as provided in the SPD 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 (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

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

**3.05A Reduction of Certain Elections to Prevent Discrimination.** If the Plan Administrator determines, before or during any Plan Year, that the Health 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 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 Nonelective 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 to provide Health Care Reimbursement for expenses incurred during the Plan Year. Notwithstanding the foregoing, the Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Medical Expenses incurred during the grace period. In no event can the grace period exceed two (2) months and fifteen (15) days following the end of the Plan Year.

In lieu of a grace period, the Employer may also elect to carryover up to $500 of any unused Reimbursement Account balance at the end of the Plan Year to the next Plan Year. Carryovers will be administered consistent with the terms of IRS Notice 2013-71 and IRS CCM 201413005. The Employer may require or allow participants who elect Health Savings Account compatible

coverage for the next Plan Year to carryover unused Health Care Reimbursement Account balances to a limited-scope option of reimbursement under the Health FSA (if selected in the Plan Information Summary and as set forth in the SPD). In addition, the Plan Administrator may permit an individual to decline or waive any carryover of an unused general Reimbursement Account balance to the next Plan Year before the beginning of that next Plan Year.

If a grace period or carryover is adopted, all amounts allocated to the Health FSA during a Plan Year that are not used to reimburse Eligible Medical Expenses incurred during the Plan Year and/or the Grace Period or not carried over shall be forfeited. 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, including the amount of the carryover (if any), shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

**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 (or during the grace period to the extent adopted by the Employer) 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 expense with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the SPD.

**4.03A Substantiation of Expenses.** Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD and provide the required substantiation set forth in the SPD 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 shall take the following steps in any order on a uniform and nondiscriminatory basis to recover an excess reimbursement that is discovered during the Plan Year in which the excess reimbursement occurred: (i) The Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of the excess reimbursement to the Employer within sixty (60) days of receipt of such notification (the Participant's electronic payment card, if any, will be suspended until the excess reimbursement is recovered). (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement. (iii) withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth in (i) – (iii), or if the Plan Administrator did not apply the methods in (i)-(iii) during the Plan Year that the excess reimbursement was made to the employee, the Plan 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. If the funds cannot be recouped the Employer will report the excess reimbursement on a Form W-2, subject to withholding for applicable income and employment taxes, in the tax year of the Employee that the debt is forgiven.

**4.05A Reimbursement Following Cessation of Participation.** Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expense 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 set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, 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) 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.

**4.07A Disbursement Reports.** The Plan Administrator 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 its designated third-party administrator may periodically furnish each Participant with a statement, showing 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 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 Administrator, no benefit under the Health FSA 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 Health FSA 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 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 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 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 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.** Any Health 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 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 Nonelective 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.

## ARTICLE VIIA
## CONTINUATION COVERAGE UNDER COBRA

The SPD includes COBRA continuation of coverage provisions that shall be applicable to the Health FSA, to the extent the plan sponsor is subject to COBRA (as it amended ERISA, the Code, and the Public Health Service Act).

## ARTICLE VIIIA
## HIPAA PRIVACY AND SECURITY

**8.01A General.** The Employer has elected to treat the Plan as a Hybrid Entity within the meaning of HIPAA and the regulations issued thereunder (referred to herein as the "Privacy Rule"). The Health Care Components of the Plan identified and designated in Section 8.02A below are subject to this Article VIIIA and shall comply with the standards for privacy of individually identifiable health information as set forth in the Privacy Rule and, the security standards for the protection of Electronic PHI as set forth in the Security Rule. The Plan Administrator also intends the Plan to form part of an Organized Health Care Arrangement, as defined under 45 C.F.R. § 160.103, along with any benefit under any other Health Plan provided by the Employer.

**8.02A Definitions.** For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI. A Breach does not include:

(i) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;

(ii) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or

(iii) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(c) "Health Care Component," as defined under 45 C.F.R. Section 164.103, means a component or combination of components of a Hybrid Entity designated by the Hybrid Entity in accordance with 45 C.F.R. Section 164.105(a)(2)(iii)(C). Unless coverage is provided under a fully insured arrangement, the Employer has designated the HIPAA Programs of the Plan which provide medical coverage (i.e., the health care account coverage), as Health Care Components subject to this Article.

(d) "Health Care Operations," as defined under 45 C.F.R. Section 164.501, means any of the following activities to the extent that they are related to a HIPAA Health Plan's covered functions:

(i) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;

(ii) Reviewing competence or qualifications of health care professionals and evaluating provider and HIPAA Health Plan performance;

(iii) Underwriting and other activities that relate to the creation, renewal or replacement of a contract of health insurance or health benefits; and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);

(iv) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(v) Business planning and development, such as cost-management and planning-related analysis related to managing and operating the HIPAA Health Plan, and development or improvement of coverage policies; and

(vi) Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for the HIPAA Health Plan sponsor, provided that PHI is not disclosed to the HIPAA Health Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger or consolidation of all or part of a HIPAA Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. Section 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. Section 164.514(d)(2).

(e) "Health Plan" means each "group health plan," as defined in 45 C.F.R. Section 160.103, sponsored by the Employer to provide health care benefits for its employees, former employees and dependents, including the designated Health Care Components.

(f) "HIPAA Health Plan" as defined under 45 C.F.R. Section 160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 C.F.R. Section 160.103.

(g) "Hybrid Entity," as defined under 45 C.F.R. Section 164.103, means a single legal entity that is a covered entity whose business activities include both covered and non-covered functions, and that designates Health Care Components in accordance with 45 C.F.R. Section 164.105(a)(2)(iii)(C).

(h) "Payment," as defined under 45 C.F.R. Section 164.501, means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.

(i) "Privacy Policy" means the Company's internal HIPAA privacy and security policies and procedures.

(j) "Protected Health Information" or "PHI" means individually identifiable health information that (i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received, created, maintained or transmitted by or on behalf of a Health Plan.

(k) "Responsible Employee" means an employee (including a contract, temporary or leased employee) of the Health Plans or of the Employer whose duties (A) require that the employee have access to PHI for purposes of Health Plan Payment or Health Care Operations; or (B) make it likely that he will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 8.03A. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates, receives, maintains or transmits PHI on behalf of a Health Plan, even though his duties do not (or are not expected to) include creating, receiving, maintaining or transmitting PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health Plan functions.

(l) "Security Incident" as defined under 45 C.F.R. Section 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(m) "Security Rule" means the regulations issued under HIPAA concerning the security of Electronic PHI.

**8.03A Responsible Employees.** Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health Plan administration functions that the Employer performs on behalf of a Health Plan pursuant to Section 8.04A.

(a) Employer employees who perform the following functions on behalf of the Health Plans are Responsible Employees:

(i) claims determination and processing functions;

(ii) Health Plan vendor relations functions;

(iii) benefits education and information functions;

(iv) Health Plan administration activities;

(v) legal department activities;

(vi) Health Plan compliance activities;

(vii) information systems support activities;

(viii) internal audit functions; and

(ix) human resources functions.

(b) In addition to those individuals described in subsection (a), the Administrator who performs claims appeals and other decision-making functions on behalf of the Health Plans, the Health Plans' HIPAA privacy officer and security official, and Employer employees to whom the Health Plans' HIPAA privacy officer and security official has delegated any of the following responsibilities shall also be Responsible Employees:

(i) implementation, interpretation and amendment of the Privacy Policy;

(ii) Privacy Rule or Security Rule training for Employer employees;

(iii) investigation of and response to complaints by Participants and/or employees;

(iv) preparation and maintenance of the Health Care Components' privacy notice;

(v) distribution of the Health Care Components' privacy notice;

(vi) response to requests by Participants to inspect or copy PHI;

(vii) response to requests by Participants to restrict the use or disclosure of their PHI;

(viii) response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;

(ix) amendment and response to requests to amend Participants' PHI;

(x) response to requests by Participants for an accounting of disclosures of their PHI;

(xi) response to requests for information by the Department of Health and Human Services;

(xii) approval of disclosures to law enforcement or to the military for government purposes;

(xiii) maintenance of records and other documentation required by the Privacy Rule or Security Rule;

(xiv) negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;

(xv) maintenance of Health Plan PHI or Electronic PHI security documentation; or

(xvi) approval of access to Electronic PHI.

**8.04A Permitted Uses and Disclosures.** Responsible Employees may access, request, receive, use, disclose, create and/or transmit PHI only to perform certain permitted and required functions on behalf of Health Care Components, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health Care Components' own Payment and Health Care Operations functions;

(b) uses and disclosures for another Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 C.F.R. Section 160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan Sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Care Components or for making decisions to modify, amend or terminate the Health Care Components; or (ii) enrollment or disenrollment information;

(e) disclosures of a Participant's PHI to the Participant or his personal representative, as defined under 45 C.F.R. Section 164.502(g);

(f) disclosures to a HIPAA Health Plan for the other HIPAA Health Plan's Payment or Health Care Operations activities;

(g) disclosures to a Participant's family members or friends involved in the Participant's health care or payment for the Participant's health care, or to notify a Participant's family in the event of an emergency or disaster relief situation;

(h) uses and disclosures to comply with workers' compensation laws;

(i) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;

(j) disclosures to the Secretary of Health and Human Services to demonstrate the Health Care Components' compliance with the Privacy Rule or Security Rule;

(k) uses and disclosures for other governmental purposes, such as for national security purposes;

(l) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(m) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(n) uses and disclosures required by other applicable laws; and

(o) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 C.F.R. Section 164.508.

Notwithstanding anything in the Plan to the contrary, the use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not

be permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal or replacement of a contract of health insurance.

**8.05A Certification Requirement.** The Health Care Components shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI, received from the Health Care Components agree:

(i) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and

(ii) implement reasonable and appropriate security measures to protect such Electronic PHI.

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health Care Components any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 8.04A, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 C.F.R. Section 164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(h) to make its internal practices, books and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health Care Components available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Care Components with the Privacy Rule or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI, received from the Health Care Components that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

(j) to take reasonable steps to ensure that there is adequate separation between the Health Care Components and the Employer's activities in its role as Plan sponsor and

employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Health Care Components.

**8.06A Mitigation.** In the event of non-compliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document his investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

**8.07A Breach Notification.** Following the discovery of a Breach of unsecured PHI, a Health Care Component shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. Section 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, a Health Care Component shall notify the media in accordance with 45 C.F.R. Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

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

**Clay County Board of Supervisors**

By: _____

Title: President

Date: 8/19/2015

# DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

APPENDIX B TO THE

**CLAY COUNTY BOARD OF SUPERVISORS**

**CAFETERIA PLAN**

The Effective Date of this Document is 07/01/2019.

## TABLE OF CONTENTS

## PREAMBLE

Effective as of the date set forth below, the Clay County Board of Supervisors established this Dependent Care Spending Account (the Dependent Care FSA) 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 Reimbursement Account established pursuant to this Dependent Care FSA. This Dependent Care FSA 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 be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code. This Dependent Care FSA is a component of and incorporated by reference into the Clay County Board of Supervisors Cafeteria Plan, and Articles VI, IX and X of the Cafeteria Plan document apply also to this Dependent Care FSA.

## 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.

**1.01B "Dependent"** means any individual who is a tax dependent of the Participant as defined in Code Section 152 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. .

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

**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 means 07/01/2019.

**1.05B "Eligible Employment Related Expenses"** means those 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 Section 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(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation 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 shall be eligible to participate in this Dependent Care FSA as of the Dependent Care Eligibility Date set forth in the SPD.

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

**2.03B Qualifying Leave Under Family Leave Act.** Notwithstanding any provision to the contrary in this Dependent Care FSA, if a Participant goes on a qualifying leave under the Family and 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. 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 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 as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party

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 3.02B, 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 third party administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Dependent Care FSA as set forth in the SPD (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 3.02B or 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 material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

**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, 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 and Medical Leave Act. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

**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.

**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
## REIMBURSEMENTS

**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 Nonelective 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 to provide Dependent Care Reimbursement for Eligible Day Care Expenses incurred during the Plan Year. The Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Day Care Expenses incurred during the grace period. In no event can the grace period exceed two (2) months and fifteen (15) days following the end of the Plan Year. All amounts allocated to the Dependent Care FSA that are not used to reimburse Eligible Day Care Expenses incurred during the Plan year and/or the Grace Period shall be forfeited. 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. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

**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 (or the grace period, if adopted by the Employer), 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.

**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, the Plan Administrator 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.

**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 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. To the extent set forth in the SPD, Participants may submit claims for reimbursement of Eligible Employment-Related Expenses incurred during the Plan Year and after they cease participation 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) shall be treated in accordance with Section 4.01B.

**4.06B Disbursement Reports.** The Plan Administrator 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 third-party administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Dependent Care Reimbursement 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 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 Administrator, no benefit under the Dependent Care FSA 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 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 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 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 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.** 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 shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements, and/or Nonelective 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.

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

**Clay County Board of Supervisors**

By: _____

Title: _____

Date: 8/19/2019

# CLAY COUNTY BOARD OF SUPERVISORS
# SUMMARY PLAN DESCRIPTION
## for the
## Cafeteria Plan
## Health Flexible Spending Account
## Dependent Care Flexible Spending Account

**Effective July 1, 2019**

## TABLE OF CONTENTS

## CLAY COUNTY BOARD OF SUPERVISORS
## SUMMARY PLAN DESCRIPTION

### GENERAL INFORMATION ABOUT THE PLAN

The Clay County Board of Supervisors is pleased to sponsor an employee benefit program known as the (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). Alternatively, you may choose to pay for any of the available benefits with after-tax payroll deductions to the extent set forth in your enrollment materials.

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) The Health Flexible Spending Account ("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.

(iii) The Dependent Care Spending Account ("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.

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. For example, you can find the identity of the Third Party 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 Clay County Board of Supervisors. The SPD (collectively, the Summary Plan Description or "SPD") describes 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 Administrator (who is identified in the Plan Information Summary).

## 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 Third Party 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 Third Party 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. NOTE: Although coverage under a Benefit Option may be retroactively effective, the Pre-tax Salary Reduction elections made under this plan are typically effective on a prospective basis only.

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 tax advantages and disadvantages of participating in the Cafeteria Plan?** You will 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 and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

**Q-6. What are the election periods for entering 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 on 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 material. 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 material 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 material distributed to you prior to the Annual Election Period. The election that you make during the Annual 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 may 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." Alternatively, the Plan Administrator may deem you to have elected not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The consequences of failing to make an election under this Plan during the Annual Election Period are described in the Plan Information Summary.

**Special Rule for Flexible Spending Account elections: Evergreen Elections do not apply to Flexible Spending Account elections. Consequently, you must make an election each Annual Election Period in order to participate in the Flexible Spending Accounts during the next Plan Year.**

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. Alternatively, your Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material 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. **NOTE: see the Health FSA Component of this SPD for special rules relating to Health FSA elections.**

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 material or in the Plan Information Summary.

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 material.

**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.

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.

Fourth, the Plan Administrator may permit employees who experience a reduction in hours below 30 hours of service per week without loss of eligibility for major medical coverage to revoke

major medical coverage for the employee, spouse, and/or dependent(s) on a prospective basis to the extent consistent with IRS Notice 2014-55 if the:

1. Employee was in an employment status where he was reasonably expected to work at least 30 hours per week *and* there is a change in his employment status so that he will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the major medical plan; and

2. revocation of the election of coverage under the major medical plan corresponds to intended enrollment of the employee, spouse, and dependents (as applicable), in another plan that provides minimum essential coverage effective no later than the first day of the second month after the month that includes the date this coverage is revoked.

And, the Plan Administrator may permit employees to revoke major medical coverage for the employee, spouse, and/or dependent(s) on a prospective basis to the extent consistent with IRS Notice 2014-55 if the:

1. Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

2. The revocation of the election under the major medical plan corresponds to the intended enrollment of the employee, spouse, and dependents for whom coverage is revoked in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of major medical plan coverage.

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**, the Election Change Chart or Benefit Option summary, whichever is applicable, controls.

(a) If you go on a qualifying unpaid leave under the Family and 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,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).

(iii) By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator 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 Administrator. 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. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(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) 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 pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the 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 (e.g. an election change or other issue germane to Pre-tax Contributions) 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.

## HEALTH FSA COMPONENT SUMMARY

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

Each Employee who satisfies the Health FSA Eligibility Requirements and who is eligible to participate in the Employer's major medical plan is eligible to participate on the Health FSA Eligibility Date. The Health FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

**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 Health Care Reimbursement benefits 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 and it will generally be effective for the remainder of the year, even if you cease to be an eligible employee (see **Q-4** of this Health FSA Component for more information on when your coverage ends). If you made an election to participate during one plan year 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. 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 in accordance with federal law);
(ii) Your child, until the end of the year in which your child turns age 26; and
(iii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

For purposes of (ii) above, your "child" means your son, daughter, stepchild, foster child, legally adopted child, or child placed with you for legal adoption, regardless of such child's tax dependent status, marital status, employment status, student status or residency. 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 Employee and child(ren) only Election:** Your participation in this Health FSA could disqualify your spouse from establishing and making/receiving tax favored contributions to a health savings account as defined in Code Section 223 unless you have elected the limited reimbursement option set forth below. If a spouse maintains a Code Section 223 health savings account or wishes to establish a Code Section 223 health savings account, you may make an election during the initial enrollment period and/or the annual enrollment period to exclude your spouse from coverage under the Health FSA and cover only the participant and the participant's eligible dependents.

**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 last day of the Plan Year, even if you terminate employment, except that coverage ends on the date of the earliest of the following to occur:

(i) The date that you elect to revoke your Health FSA election in accordance with the Cafeteria Plan Summary;
(ii) 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.

Coverage for your Eligible Dependents ends on 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.

Your covered spouse and/or covered children 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 ever change my Health FSA election?**

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

(i) *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 and, notwithstanding anything to the contrary in this SPD, as a result of your termination of employment/ceasing to be an eligible employee.**

**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. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Effective for taxable years beginning on or after January 1, 2013, Health FSA salary reductions are limited to $2500.00 each year. The limit is indexed for inflation based on the CPI beginning in 2014.

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 claims 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. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution allocated to your Health Care.

**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 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?**

Under this Health FSA (if your Employer offers the Electronic Payment Card), 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 the 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 Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., an Itemized 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 or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Third Party 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 make an election to use the card.* 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. You may not use the card 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 FSA reimbursement under the card is limited to health care providers (including pharmacies).* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at certain retail stores.

(e) *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. 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 swipe the card. Every time you swipe 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 an itemized statement /third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., itemized statement, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug or a box top is to be included
- The date the expense was incurred.
- The amount of the expense.

You must retain this documentation 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 is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a notification from the Claims Administrator if a third party statement is needed. You must provide the third party statement to the Claims Administrator within 7 days (or such longer period provided in the notification from the Claims Administrator) of the request.

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

- **Co-Pay Match:** Written statement 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 Claims Administrator.
- **Previously Approved Claim Match:** Written statement may not be required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt may not need to be provided to the Claims Administrator if the expense incurred is the same amount.
- **Provider Match Program:** Third party statement may not be required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount).

*Note: You should still obtain the third party statement when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims 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 Claims 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) *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.

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 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 Third Party 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 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 Plan Administrator), taking into account quantity limitations, etc...

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.

*If you currently maintain or wish to establish a personal Health Savings Account (Limited Reimbursement Option), you may be able to make an election to limit the scope of your coverage as set forth below but only to the extent Limited Scope Coverage is identified as an option in the Plan Information Summary.*

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)
(ii) Services or treatments for vision care (excluding premiums)
(iii) Services or treatments for "preventive care" Preventive care is defined in accordance with applicable rules and regulations. This may include any prescribed drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic), (b) to prevent the recurrence of a condition from which the eligible individual has recovered, or (c) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

To the extent identified as an option in the Plan Information Summary, you may elect the limited-scope health FSA during Initial and/or Annual Enrollment Period.

**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. 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).

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in the Plan Information Summary.

In lieu of adopting a grace period, the Employer may instead permit you to carryover from year-to-year up to $500 of amounts allocated to a Health Care Account that are unused at the end of the Plan Year for expenses incurred in the next Plan Year. The terms of the "carryover," if adopted, will be described in the Plan Information Summary.

**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 Plan Administrator's sole discretion).

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. If the Employer instead adopted a carryover, up to $500 of the unused amount remaining at the end of the Plan Year can be carried over to the next Plan Year and used to reimburse expenses incurred during the next Plan Year. Any amounts not used for expenses incurred during the Plan Year and during the grace period, or that are not permitted to be carried over, will be forfeited.

**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.

**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 Plan 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" for purposes of this Plan is 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. Divorce or Legal Separation | | √ | |
| 2. Child ceasing to be an eligible dependent | | | √ |
| 3. Death of the covered employee | | √ | √ |

**NOTE:** Notwithstanding the preceding provisions, a Qualified Beneficiary generally does 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 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 continuation coverage is chosen, the Qualified Beneficiary may continue the level of coverage in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for all Qualified Beneficiaries as well. After electing COBRA coverage, the Qualified Beneficiary 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 continuation coverage is not chosen, the Qualified Beneficiary's 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 COBRA Administrator (if a COBRA Administrator 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 COBRA Administrator is notified that one of these events has occurred, the Plan 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 COBRA Administrator 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, the Qualified Beneficiary must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date coverage would be lost as a result of one of the qualifying events identified above or the date the notice of your right to elect continuation coverage is sent, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of all continuation coverage rights.

Cost

The Qualified Beneficiary will have to pay the entire cost of his/her continuation coverage. The cost of 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 the election is made. Subsequent contributions are due the 1st day of each month; however, a Qualified Beneficiary will have a 30-day grace period following the due date in which to make the required contribution. Failure to make contributions within this time period will result in automatic termination of 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. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for 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 the Qualified Beneficiary becomes covered under another group health plan and is not actually subject to a pre-existing condition exclusion limitation;
- if the Qualified Beneficiary becomes 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 Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that you receive an excess payment: (i) The Plan Administrator 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 Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement; or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year that the excess reimbursement was made, the Plan 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 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'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? (Only if Applicable)**

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA sponsored by the Employer that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the Health FSA or HRA must pay first.

## MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

**ERISA Rights (not applicable to non-ERISA Plans)**

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

*Receive Information about Your Plan and Benefits*

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

*Continue Group Health Plan Coverage*

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review **Q-16.** of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

*(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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

*Prudent Actions by Plan Fiduciaries*

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person,

may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

*Enforce Your Rights*

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

*Assistance with Your Questions*

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## DEPENDENT CARE FSA COMPONENT SUMMARY

**Q-1. Who can participate in the Plan?**

Each employee who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date. The Dependent Care FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

**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 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 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 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.

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 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 benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care 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 my coverage under the Dependent Care FSA end?**

Your coverage under the Dependent Care 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 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.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Day Care Expenses incurred after the date of separation up to the amount of your Dependent Care Account *to the extent set forth in the Plan Information Summary.*

**Q-5. Can I ever change my Dependent Care FSA election?**

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

(i) *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 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 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 and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence.

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

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. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, allocated your Dependent Care Account.

**Q-9. What is an "Eligible Day Care Expense" for which I can claim a reimbursement?**

You may be reimbursed for work-related dependent care expenses ("Eligible Day Care Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care 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 as defined in Code Section 152 (including a brother, sister, step sibling, 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 generally in Code Section 21) 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. For purposes of this Dependent Care FSA only, a "Dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d) (applicable to "Qualifying Relatives" as defined in Code Section 152); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (i.e. a child of divorced or separated parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child on his or her tax return.

3. The expense is incurred for the custodial 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 or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires

you to pay for day care. Expenses for overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, day camps are considered to be for custodial care even if they also provide educational activities.

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 spends 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 care is not provided by 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. Moreover, the care cannot be provided by a parent of the Qualifying Individual.

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 503 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Day Care 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 (if your Employer offers the Electronic Payment Card), you have two reimbursement options. You can complete and submit a written claim for reimbursement ("traditional paper claim") or, alternatively, if offered with your Plan, you can use an electronic payment card to pay the expense. The following is a summary of how both options work.

*Traditional Paper Claims*: If you have elected to participate in the Dependent Care FSA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. You may obtain a Request for Reimbursement form from the Plan Administrator or Third Party Administrator. You must include with your request for Reimbursement. 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 balance becomes adequate. Remember, though, that you can't be reimbursed for any

total expenses above your available, annual 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.

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

(a) *You must make an election to use the card.* If you wish to use an electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program (including limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.) both during the Initial Election Period and during each Annual Election Period. An Electronic Payment Card Program 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 Electronic Payment Card Program Agreement during the preceding Annual Election Period. The Electronic Payment Card 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.

(c) *You must certify proper use of the card.* As specified in the Electronic Payment Card Program Agreement, you certify during the applicable Election Period that the card will only be used for Eligible Employment Related Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. **You also certify that you will not use the card for expenses in advance of the date the services giving rise to such expenses are provided.** Failure to abide by this certification will result in termination of card use privileges.

(d) *The card may be limited to certain providers.* Use of the card may be limited to certain merchants who are dependent care providers. As set forth in the Electronic Payment Card Program Agreement, you will not be able to use the card at a regular retail store.

(e) *You swipe the card at the day care provider like you do any other credit or debit card.* When you incur an Eligible Employment Related Expense, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available at that time you swipe the card. Every time you swipe the card, you make the same certifications that you agree to make the same certifications referenced in (c) above.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the day care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

- The name of the person receiving the service.

- The name and address of the service provider.
- The nature of the service.
- The amount of the reimbursable expense under the plan.
- The date(s) of service.
- The Provider's Tax ID or Social Security Number.

Even though payment is made under the electronic payment card arrangement, a written third party statement is required to be submitted to substantiate the expense. If you do not submit a written third party statement, you will receive a notification (via mail or email) from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within 7 days (or such longer period provided in the notification from the Claims Administrator) of the request.

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims 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) *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.

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

Eligible Day Care Expenses must be incurred ***during*** the Plan Year. 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, or for any expenses 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.

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in the Plan Information Summary.

**Q-12. What if the Eligible Day Care 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.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and the grace period will be forfeited.

**Q-13. Will I be taxed on the Dependent Care Reimbursement benefits 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 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 credit (the amount that serves as the basis for the calculation of the applicable credit is reduced by all amounts that you receive under this Plan).

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

The household and dependent care 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, 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 adjusted gross income 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 adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the 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 adjusted gross income 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 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.

**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 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 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 may recoup the excess reimbursements in one or more of the following ways: (i) The Plan 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 Plan 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 Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (i) – (iii), the Plan 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 Clay County Board of Supervisors. The Effective Date of this Plan Information Summary is July 1, 2019. This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.**

### I. EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

| | |
|---|---|
| 1. Name, address, and telephone number of the Employer/Plan Sponsor: | Clay County Board of Supervisors<br>P.O. Box 815<br>West Point, MS 39773<br>(662) 494-3124 |
| | |
| 2. Name, address, and telephone number of the Plan Administrator:<br><br>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. | Clay County Board of Supervisors<br>P.O. Box 815<br>West Point, MS 39773<br>(662) 494-3124 |
| | |
| 3. Employer's federal tax identification number: | 64-6000252 |
| | |
| 4. Plan Number: | 501 |
| | |
| 5. Effective Date of the Plan:<br><br>This is the date that the Plan was first established. | July 1, 2019 |
| | |
| 6. Effective Date of this SPD:<br><br>Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices. | July 1, 2019 |
| | |
| 7. Plan Year: | July 1 through June 30 |
| | |
| 8. Adopting Employers participating in the Plan: | N/A |
| 9. Third Party Administrator: | Griffing & Associates Administrators |

## II. CAFETERIA PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date.** Each Employee who is a full-time employee and who is eligible for coverage or participation under any of the Benefit Options ("Cafeteria Plan Eligibility Requirements") will be eligible to participate in this Plan on the first of the month following 30 days of employment ("Cafeteria Plan Eligibility Date").

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 Health FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in the one of following deemed election(s):

The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Options offered under the Plan will end the last day of the Plan Year made.

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 Annual Election Period took place. This is called an "Evergreen election".

(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 **thirty (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 Nonelective 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.

| | | | |
|---|---|---|---|
| 1. | **Group Health Insurance Premiums** | 6. | **Dependent Care FSA** |
| 2. | **Accident Insurance Premiums** | 7. | **Group Term Life Insurance Premiums** |
| 3. | **Cancer Insurance Premiums** | 8. | **Hospital Indemnity Insurance Premiums** |
| 4. | **Dental Insurance Premiums** | 9. | **ICU Insurance Premiums** |
| 5. | **Health FSA** | 10. | **Vision Insurance Premiums** |

## III. HEALTH FSA COMPONENT INFORMATION

(a) **Health FSA Eligibility Requirements and Eligibility Date**. Each Employee who is a full-time employee ("Health FSA Eligibility Requirements") and who is eligible to participate in the Employer's major medical plan is eligible to participate in the Health FSA on the first of the month following 30 days of employment ("Health FSA Eligibility Date").

(b) **Annual Health Care Reimbursement Amounts.** The Maximum Annual Reimbursement Amount each year may not exceed the lesser of Health FSA reimbursement amount elected for that year or $2700. The limit is indexed for inflation based on the CPI beginning in 2014.

The minimum reimbursement amount that may be elected under the Health FSA is N/A.

(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 – 60 days from the end of the Plan Year.

(ii) The Run Out Period for terminated employees – 60 days from termination date.

(d) **COBRA Administrator.** The COBRA administrator for the Health FSA is the Clay County Board of Supervisors.

(e) **Interaction with HRA.** See below regarding this Health FSA's rules with respect to coordination with an HRA:

| | |
|---|---|
| Does the Employer sponsor an HRA? | **No** |
| Does this Health FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health FSA? | **N/A** |

(f) **Method of Funding**: Health FSA Benefits are paid from general assets.

| | |
|---|---|
| Does the Employer offer a Limited-Scope Option? | **No** |

Employees may elect during the initial enrollment period and/or the annual enrollment period the limited-scope option of reimbursement under the Health FSA, as set forth in the SPD, so that the employee and/or a spouse may participate in a Health Savings Account as defined in Code Section 223. In addition, the Employer may designate Carryover amounts, if any, as being subject to the limited-scope option of reimbursement under the Health FSA if the employee elects to contribute to the HSA or elects HSA-compatible coverage.

(h) **Spousal Exclusion:**

| | |
|---|---|
| Does the Employer offer a Spousal Exclusion? | **No** |

Employees may elect during the initial enrollment period and/or the annual enrollment period to exclude the spouse from coverage under the Health FSA, as set forth in the SPD, so that the spouse may participant in a Health Savings Account as defined in Code Section 223.

## IV. DEPENDENT CARE FSA COMPONENT INFORMATION

(a) **Dependent Care FSA Eligibility Requirements and Eligibility Dates.** Each Employee who is a full-time employee ("Dependent Care FSA Eligibility Requirements") is eligible to participate in the Dependent Care FSA on the first of the month following 30 days of employment ("Dependent Care FSA Eligibility Date").

(b) **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 – 60 days from the end of the Plan Year.

(ii) The Run Out Period for terminated employees – 60 days from the termination date.

(c) **Expense incurred after termination of employment.** You **cannot** be reimbursed for Employment Related Expenses incurred after you terminate employment.

(d) **Method of Funding**: Dependent Care FSA Benefits are paid from general assets.

## V. CARRYOVER

| | |
|---|---|
| Does the Employer elect the Carryover in lieu of the Grace Period? | **Yes** |
| What is the maximum amount of the Carryover? | **$500** |
| Can an employee waive the Carryover? | **No** |

If indicated above that the Employer adopted the Carryover in lieu of a grace period, the following applies:

Up to $500 of the unused amount in a Health Care Account for a Plan Year ("Carryover Maximum") may be rolled over for use in the entire, subsequent Plan Year.

With a Carryover, Health Care Account balances that are unused for a Plan Year may be used for reimbursement of Eligible Medical Expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year)—not just during the first two (2) ½ months--subject to the following terms and conditions:

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year ("Carryover").
    - For example, if you have an unused Health FSA balance at the end of the 2019 Plan Year equal to $1000, and you have no other expenses that were incurred in 2019, your 2019 Carryover amount that may be used in the 2020 Plan Year is $500. However, if you have 2019 Plan Year expenses equal to $600 that you timely submit during the run out period for the 2019 Plan Year, then your 2019 Carryover amount that may be used in the 2020 Plan Year will only be $400.
- If you incur an eligible expense during a Plan Year ("Current Year Expense") but before the end of the prior Plan Year's run out period, the Plan Administrator may, at its discretion, apply up to $500 of the amount unused *at the end of the prior Plan Year* (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year ("Prior Year Expenses") submitted during the prior Plan Year's run out period and it will reduce the Carryover Maximum by the same amount.
    - For example, assume that you have $800 at the end of the 2019 Plan year and you have elected $2500 for the 2020 Plan Year. On February 1, 2020, you incur a $2700 eligible medical expense. The entire $2,700 expense will be reimbursed with the $2,500 elected for 2020 and $200 of the $800 unused at the end of the 2019 Plan Year. However, only $600 will be available for 2019 Plan Year expenses submitted during the run out period for the 2019 Plan Year and your 2019 Carryover Maximum is reduced to $300 ($500 maximum minus the $200 already used). Further assume that after reimbursement of the $2,700 expense that was incurred on February 1, 2020 but before the end of the run out period for the 2019 Plan Year, you submit a $750 expense incurred in 2019. Only $600 of

that 2019 expense will be reimbursed and you will have no 2019 Carryover for use in the 2020 Plan Year.

- The Carryover does not count against the maximum salary reduction election.

- If you are otherwise eligible for the Health FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

- Under IRS rules, if you have unused Health FSA amounts on the last day of a Plan Year in a general purpose Health FSA (i.e., anything other than a $0 balance), you (and your spouse, if you are married) cannot contribute to a health savings account ("HSA") under Code Section 223 during the following Plan Year. For this purpose, whether you have unused Health FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted).

  However, if the Plan Administrator allows you to waive any Carryover eligibility before the last day of the Plan Year, then you will be eligible for an HSA in the following Plan Year.

- You must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

## APPENDIX I

## CLAIMS REVIEW PROCEDURE CHART

**The Effective Date of this Appendix I is July 1, 2019. It should replace and supersede any other Appendix I with an earlier date.**

The Plan has established the following claims review procedures 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 Health FSA and Dependent Care FSA.

**Step 1:** *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party 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 Third Party Administrator, the Third Party 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 Third Party 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 Third Party Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
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;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party 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 Third Party 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 Third Party 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 Third Party Administrator.

**Step 6:** *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party 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 Third Party 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:

- (Health FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- 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 July 1, 2019. 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 major medical insurance 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 |
|---|---|---|---|
| 1. Gross Income | $50,000 | | $50,000 |
| 2. Salary Reductions for Premiums | $2,400 (pre-tax) | | $0 |
| 3. Adjusted Gross Income | $47,600 | | $50,000 |
| 4. Standard Deduction | ($10,300) | | ($10,300) |
| 5. Exemptions | ($9,900) | | ($9,900) |
| 6. Taxable Income | $27,400 | | $29,800 |
| 7. Federal Income Tax (Line 6 x applicable tax schedule) | ($3,359) | | ($3,719) |
| 8. FICA Tax (7.65% x Line 3 Amount) | ($3,641) | | ($3,825) |
| 9. After Tax Contributions | ($0) | | ($2,400) |
| 10. Pay after taxes and contributions | $40,600 | | $40,056 |
| 11. Take Home Pay Difference | $544 | | |

## APPENDIX III

## ELECTION CHANGE CHART

**The Effective Date of this Appendix III is July 1, 2019. It should replace and supersede any other Appendix III 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 chart to determine under what circumstances you are permitted to make an election 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 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 Third Party 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 Third Party 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. 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. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent. Contact the Third Party Administrator for more information.

  *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 Benefits.* 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.*

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits, if offered under the Plan. (See the list of Benefit Options offered under the Plan.)* For group term life insurance, disability income and accidental death and dismemberment benefits only if a Participant experiences any Change in Status (as described above), an election to either increase or decrease coverage is permitted.

  *Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance 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 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, exhaustion of COBRA period, or if your employer or your eligible dependent's employer stops contributing toward your or your dependents' other coverage), 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, 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) cover 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 Medicaid.** If a Participant or the Participant's Dependents become entitled to Medicare or Medicaid, 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 Medicaid 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 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 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. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. 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 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 the Health FSA, to the extent offered under the Plan.)

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 | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| **I. Change in Status** | | | | | |
| **A. Change in Employee's Legal Marital Status** | Employee may enroll or increase election for newly- eligible spouse and dependent children (Note: Under IRS "tag-along" interpretation, new and preexisting dependents may be enrolled); coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee's or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. Also, see HIPAA special enrollment rule below. | Same as previous column (Note: HIPAA special enrollment rights likely do not apply). | Employee may enroll or increase election for newly eligible spouse or dependents, or likely decrease election if employee or dependents become an eligible dependent under new spouse's health plan (Note: HIPAA special enrollment rights likely do 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 enroll, increase, decrease, or cease coverage even when eligibility is not impacted. |
| **1. 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; coverage option (e.g., HMO to PPO) change may be made; 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 divorce, legal separation, annulment, or death. (Note: Under IRS "tag-along" interpretation, any dependents may be enrolled so long as at least one dependent has lost coverage under the spouse's plan.) | Same as previous column (Note: HIPAA special enrollment rights likely do not apply). | Employee may decrease election for former spouse who loses eligibility (Note: HIPAA special enrollment rights likely do not apply). Employee may enroll or increase election where coverage 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 enroll, increase, decrease, or cease coverage even when eligibility is not impacted. |
| **B. Change in the Number of Employee's Dependents** | | | | | |
| **1. Gain Dependent** (birth, adoption) | Employee may enroll or increase coverage for newly-eligible dependent (and any other dependents who were not previously | Same as previous column (Note: HIPAA special enrollment rights likely do not apply). | Same as previous column (Note: HIPAA special enrollment rights likely do not apply). | Employee may enroll or increase to accommodate newly eligible dependents (and any other dependents who were not previously | Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | covered under IRS "tag-along" rule); coverage option (e.g., HMO to PPO) change may be made; 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. | | | covered under IRS "tag-along" rule). | |
| **2. Lose Dependent** (death) | Employee may drop coverage only for the dependent who loses eligibility; coverage option (e.g., HMO to PPO) change may be made. | Same as previous column. | Employee may decrease or cease election for dependent who loses eligibility. | Employee may decrease election for dependent who loses eligibility. | Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted. |
| **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 and coverage option (e.g., HMO to PPO) change may be made. | Same as previous column. | Same as previous column. | Same as previous column. | Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted. |
| **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 be made. | Same as previous column. | Employee may apparently decrease or cease FSA 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 enroll, increase, decrease or cease coverage even when spouse's or dependent's eligibility is not impacted. |
| **2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status)** | | | | | |
| **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 dependents who lose eligibility under the plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. Coverage option (HMO to PPO) change may be made. | Same as previous column. | Same as previous column. | Employee may revoke or decrease election to reflect loss of eligibility. | Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected. |
| **i. Termination and Rehire Within 30 Days** | Prior elections at termination are | Same as previous column. | Same as previous column. | Same as previous column. | Same as previous column. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year). | | | | |
| **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 dependents who lose eligibility under spouse's or dependent's employer's plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made; See HIPAA special enrollment rule below. | Same as previous column (Note: HIPAA special enrollment rights likely do not apply). | Employee may enroll or increase FSA election if spouse or dependent loses eligibility for health coverage (Note: HIPAA special enrollment rights likely do not apply). | 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 enroll, increase, decrease or cease even when eligibility is not affected. |
| **c. Employee's reduction in hours below 30 hours of service per week due to change in employment status without loss of eligibility** | Employee may revoke election as to employee's, spouse's, or dependent's coverage if:<br><br>1. Employee was in an employment status where he was reasonably expected to work at least 30 hours per week and there is a change in the employee's status so that employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the major medical plan; and<br><br>2. The revocation of the election of coverage under the major medical plan corresponds to intended enrollment of the employee, spouse, and dependents (as applicable), in another plan that provides | No change permitted. | No change permitted. | No change permitted. | No change permitted. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | minimum essential coverage effective no later than the 1st day of the 2nd month after the month that includes the date this coverage is revoked. | | | | |
| **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. In addition, employee may apparently add previously eligible (but not enrolled) dependents under "tag-along" rule; coverage option (e.g., HMO to PPO) change may be made. | Same as previous column. | Employee may increase election or enroll only if dependent gains eligibility under Healthcare FSA. | Employee may increase election or enroll to take into account expenses of affected dependent. | Employee may enroll, increase, decrease or cease 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 be made. | Same as previous column. | Employee may decrease election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost. | Employee may decrease or drop election to take into account expenses of affected dependent. | Employee may enroll, increase, decrease 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. Also, other previously eligible dependents may be re-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 increase or decrease even if spouse's or dependent's 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 for coverage option. | 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 enroll, increase, decrease or cease 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 | Same as previous column. | No change permitted. | Application is unclear. Presumably, plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long | Same as Major Medical column. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | make such corresponding changes. | | | as the terms of the plan require employees to make such corresponding changes. | |
| **III. Significant Cost Changes** | **Significant Cost 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. **Significant Cost Decrease:** Employees may elect coverage (even if had not participated before) with decreased cost, and may drop election for similar coverage option. Though unclear, it appears that tag-along concepts may apply. | 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. | Same as Major Medical column. |
| **IV. Significant Coverage Curtailment (With or Without Loss of Coverage)** | **Without Loss of Coverage:** Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which 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 which provides similar coverage OR drop coverage if no similar benefit package option is available. | Same as previous column. | No change permitted. | Election change may apparently 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. | 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. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | Though unclear, it appears that tag-along concepts may apply. | | | | |
| **VI. Change in Coverage Under Other Employer's Flexible Benefit Plan or Qualified Benefits Plan** (In order for election changes to be permitted under this exception, the election change must be on account of and correspond with the change in coverage under the other employer's Flexible Benefit plan or qualified benefits plan. In addition, either (1) the plan of the other employer must permit elections specified under the Regulations and an election must actually be made under such plan; or (2) the employee's Flexible Benefit plan must permit elections for a period of coverage different from that under the other employer plan ("Election Lock" rule). | Employee may decrease or revoke election for employee, spouse or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer plan. | Same as previous column. | No change permitted. | Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer plan. | Same as previous column. |
| **A. Other Employer's Plan Increases Coverage** | Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer's plan. | Same as previous column. | No change permitted. | Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer's plan | Same as previous column. |
| **B. Other Employer's Plan Decreases or Ceases Coverage** | Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan. | Same as previous column. | No change permitted. | Employee may increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan. | Same as previous column. |
| **C. Open Enrollment Under Plan of Other Employer** | Corresponding changes can be made under employer's plan. | Corresponding changes can be made under employer's plan. | No change permitted. | Corresponding changes can be made under employer's plan. | Corresponding changes can be made under employer's plan. |
| **VII. FMLA Leave (Employees can fund this coverage by (1) pre-paying their contribution obligations on a pre-tax basis (so long as the leave does not straddle two plan years); (2) making contributions on a month-by-month basis (pre-tax if they are receiving salary continuation payments); or (3) catching up** | | | | | |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| on their contributions upon returning from the leave.) | | | | | |
| A. Employee's Commencement of FMLA Leave | Employee can make same elections as employee on non-FMLA leave. An employer must allow an 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 make a new election if coverage terminated while on FMLA leave. In addition, an 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 paid leave are required to be reinstated in their elections. | Same as previous column. | Same as previous column. Note that, upon return, an 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 prorate for the missed contributions. | Employee may make a new election if coverage terminated while on FMLA leave. In addition, an 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 leave are required to be reinstated in their elections. | Same as previous column. |
| VIII. HIPAA Special Enrollment Rights and Qualified Health Plan Enrollment Periods (See related exception for addition of new dependents) | | | | | |
| A. Special Enrollment for Loss of Other Health Coverage | Employee may elect coverage for employee, spouse, or dependent who has lost other coverage (COBRA coverage exhausted or terminated, no longer eligible for non-COBRA coverage or employer contributions for non-COBRA coverage terminated, etc.) Though unclear, it appears that tag-along concepts may apply. | No change permitted, unless plan is subject to HIPAA. | No change permitted, unless Healthcare FSA is subject to HIPAA. | No change permitted. | No change permitted. |
| B. Special Enrollment | Employee may elect | No change permitted, | No change permitted, | No change permitted. | No change permitted. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| **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 date of birth, adoption, or placement for adoption; employee may change salary reduction election to pay for extra cost of child's coverage retroactive to date of birth, adoption, or placement for adoption. For marriage, coverage is effective prospectively. | coverage for employee, spouse, or dependent. Example provides that election of coverage may also extend to previously eligible (but not yet enrolled) dependents. | unless plan is subject to HIPAA. | unless Healthcare FSA is subject to HIPAA. | | |
| **C. Special Enrollment for Loss of Medicaid or SCHIP Coverage** (applies beginning April 1, 2009). Note: There is a 60-day special enrollment period for this event. | Employee may elect coverage for employee or dependent who has lost Medicaid or SCHIP coverage. | Same as previous column if plan is subject to HIPAA portability rules | No change permitted, unless plan is subject to HIPAA. | No change permitted | No change permitted |
| **D. Special Enrollment Due to Eligibility for State Premium Assistance Subsidy From Medicaid or SCHIP** (applies beginning April 1, 2009). Note: There is a 60-day special enrollment period for this event. | Employee may elect coverage for employee or dependent who has become eligible for premium assistance subsidy from Medicaid or SCHIP | Same as previous column if plan is subject to HIPAA portability rules | Premium assistance subsidy does not apply | No change permitted | No change permitted |
| **E. Special Enrollment Period or annual enrollment period in Qualified Health Plan on Marketplace (a.k.a., "Exchange")** | Employee may revoke election as to employee's, spouse's, or dependent's coverage if:<br><br>1. Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance | No change permitted. | No change permitted. | No change permitted. | No change permitted. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| | issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and<br><br>2. The revocation of the election under the group health plan corresponds to the intended enrollment of the employee, spouse, and dependents for whom coverage is revoked in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of group health plan coverage. | | | | |
| **IX. COBRA Events** | Employee may increase pre-tax contributions under employer's plan for coverage if COBRA event (or similar state law continuation coverage event) occurs with respect to the employee, spouse, or dependents with respect to which the COBRA qualifying event occurred (such as a loss of eligibility for regular coverage due to loss of dependent status or a reduction in hours, etc.) and if applicable, the individual still qualifies as a tax dependent of employee. | Same as previous column. | No change permitted. | No change permitted. | No change permitted. |
| **X. Judgment, Decree, or Order** | | | | | |
| **A. Order That Requires Coverage for the Child Under Employee's Plan** | Employee may change election to provide coverage for the child. Though unclear, it appears that tag-along concepts may apply. | Same as previous column. | Same as previous column. | No change permitted. | No change permitted. |
| **B. Order That** | Employee may change | Same as previous | Same as previous | No change permitted. | No change permitted. |

| Event | Major Medical | Dental and Vision | Medical FSA | Dependent Care FSA | Employee Group Life, AD&D and Disability Coverage |
|---|---|---|---|---|---|
| **Requires Spouse, Former Spouse, or Other Individual to Provide Coverage for the Child** | election to cancel coverage for the child. | column. | column. | | |
| **XI. Medicare or Medicaid** | | | | | |
| **A. Employee, Spouse, or Dependent Enrolled in Employer's Accident or Health Plan Becomes Entitled to Medicare or Medicaid (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 apparently decrease or revoke election or increase election if Medical FSA is dropped due to Medicare (-aid) and prior employer coverage was more comprehensive. | No change permitted. | No change permitted. |
| **B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines)** | Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable. Though unclear, it appears that tag-along concepts may apply. | Unlikely that employee can elect to add dental or vision coverage; presumably, employee cannot. | Employee may apparently increase or decrease or revoke election where employer plan elected due to loss of eligibility for Medicare (-aid) is more comprehensive than Medicare (-aid). | No change permitted. | No change permitted. |
| | | | | | |