THE BOARD OF COMMISSIONERS OF DELAWARE COUNTY MET IN REGULAR SESSION ON THIS DATE WITH THE FOLLOWING MEMBERS PRESENT:

Present:
Gary Merrell, President
Barb Lewis, Vice President

Absent:
Jeff Benton, Commissioner

1
RESOLUTION NO. 18-121

IN THE MATTER OF APPROVING THE ELECTRONIC RECORD OF THE PROCEEDINGS FROM REGULAR MEETING HELD FEBRUARY 5, 2018:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

WHEREAS, the Board of Commissioners of Delaware County, Ohio (the "Board") met in regular session on February 5, 2018; and

WHEREAS, the Clerk of the Board has certified, pursuant to section 305.12 of the Ohio Revised Code, that the entire record of the proceedings at that meeting is completely and accurately captured in the electronic record of those proceedings;

NOW, THEREFORE, BE IT RESOLVED that the Board hereby approves the electronic record of proceedings at the previous meeting.

Vote on Motion Mr. Merrell Aye Mrs. Lewis Aye Mr. Benton Absent

2
PUBLIC COMMENT

3
ELECTED OFFICIAL COMMENT

4
RESOLUTION NO. 18-122

IN THE MATTER OF APPROVING PURCHASE ORDERS:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the Purchase Orders as listed below:

PR	Vendor Name	Line Description	Line Account	Amount
R1801842	BRUNER CORPORATION	HVAC MAINTENANCE AGREEMENT - WILLIS BUILDING	10011105 - 5325	$5,580.00
R1801842	BRUNER CORPORATION	HVAC MAINTENANCE AGREEMENT - COURTHOUSE	10011105 - 5325	$9,024.00
R1801973	360WATER INC	SAFETY TRAINING 2018 - ANNUAL SUBSCRIPTION	66211901 - 5305	$9,000.00
R1801987	LIBERTY BLUFF DEVELOPMENT CO LLC	SECTION 1 & 2	66211902 - 5319	$29,562.00

Vote on Motion Mrs. Lewis Aye Mr. Merrell Aye Mr. Benton Absent

5
RESOLUTION NO. 18-123

IN THE MATTER OF APPROVING TRAVEL EXPENSE REQUESTS:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

The Job and Family Services Department is requesting that Sherry Melvin and Allison Pittman attend a 2018 Council on Welfare Fraud Conference in Mt. Sterling, Ohio from April 19-20, 2018 at the cost of $516.20.

The Regional Sewer District is requesting that Mike Frommer, Tiffany Maag, Kelly Thiel, Erik McPeek, Cory Smith, Julie McGill and Liz Buening attend a One Water Government & Regulatory Affairs Workshop in Lewis Center, Ohio on March 8, 2018 at a total cost of $1,065.00 from fund 66211902.

The Regional Sewer District is requesting that Tiffany Maag attend a SEOWEA Section Meeting in Zanesville, Ohio on February 8, 2018 at a total cost of $50.00 from fund 66211902.

Vote on Motion Mr. Benton Absent Mr. Merrell Aye Mrs. Lewis Aye

6
RESOLUTION NO. 18-124

IN THE MATTER OF APPROVING AMENDMENT 1 TO THE SOFTWARE LICENSE AGREEMENTS BETWEEN THE PARTIES COURTVIEW JUSTICE SOLUTIONS INC. D/B/A EQUIVANT F/K/A MAXIMUS, THE BOARD OF DELAWARE COUNTY COMMISSIONERS, THE DELAWARE COUNTY CLERK OF COURTS OFFICE, AND THE DELAWARE COUNTY JUVENILE AND PROBATE COURT FOR THE CASE MANAGEMENT SYSTEM:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

Whereas, the Clerk Of Courts and The Juvenile and Probate Court recommend approval of Amendment 1 To The Software License Agreements Between The Parties Courtview Justice Solutions Inc. D/B/A Equivant F/K/A Maximus, The Board Of Delaware County Commissioners, The Delaware County Clerk Of Courts Office, and The Delaware County Juvenile And Probate Court For The Case Management System;

Therefore Be It Resolved, that the Delaware County Board of Commissioners approve Amendment 1 To The Software License Agreements Between The Parties Courtview Justice Solutions Inc. D/B/A Equivant F/K/A Maximus, The Board Of Delaware County Commissioners, The Delaware County Clerk Of Courts Office, and The Delaware County Juvenile And Probate Court For The Case Management System;

AMENDMENT 1
SOFTWARE LICENSE AGREEMENT

This AMENDMENT 1 SOFTWARE LICENSE AGREEMENT ("Amendment 1") amends the SOFTWARE LICENSE AGREEMENT ("SLA") dated December 13, 2004 between the parties CourtView Justice Solutions Inc. d/b/a equivant f/k/a MAXIMUS ("equivant"), a Delaware Corporation, with offices at 4825 Higbee Ave NW, Canton, OH 44718, and the Board of Commissioners, Delaware County, Ohio ("Board") whose principal offices are located at 101 North Sandusky Street, Delaware, Ohio 43015 on behalf of the Clerk of Courts of the Delaware County Common Pleas Court ("Clerk"), with offices at 110 North Sandusky St., Delaware, Ohio 43015.

IN CONSIDERATION OF the parties agreeing to amend their obligations in the existing SLA, the mutual benefits derived from this Amendment 1, and other valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to keep, perform and fulfill the promises, conditions and agreements below.

BACKGROUND

1. The Board on behalf of the Court originally entered the SLA with MAXIMUS;
2. The original date of the SLA was December 13, 2004;
3. CourtView Justice Solutions Inc. d/b/a equivant is the successor of MAXIMUS;
4. The original number of licenses purchased by the Clerk was 20 (twenty).

AMENDMENT

1. The SLA is amended in regard to the license count for the Clerk with respect to the different CourtView Software products described hereunder;
2. The Delaware County Juvenile and Probate Court ("Court") is transferring fifteen (15) licenses to the Clerk;
3. As a result of such transfer, the license count of the Clerk shall be increased from 20 (twenty) to 35 (thirty five) licenses effective the date the last party signs this Amendment 1 ("Effective Date");
4. The content of Schedule A of the SLA entitled "MAXIMUS APPLICATION SOFTWARE SYSTEMS COVERED UNDER THIS AGREEMENT," which currently reads as follows:

   (1) Case Management Module
   (2) Judicial Management Module
   (3) Financial Management Module
   (4) Account Receivable Module
   (5) Web-based Public Access Module

   Shall be replaced with the following
   COURTVIEW APPLICATIONS:

SOFTWARE	LICENSE
CourtView Case Management	35
CourtView Case Management (Public Defender's Office)	2
CourtView eServices eAccess Portal	2
CourtView eAccess Imaging Adapter	2
CourtView eServices ePay	1
Uniface Web Deployment License (Third Party Software)	1
CourtView JusticeFiling	1
CourtView Ohio Tax Lien	1

CourtView Dashboards 35

5. All license fees for the twenty (20) licenses originally included in the SLA have to-date been paid in-full. The license fees for the fifteen (15) transferred licenses were paid for in-full by the Court pursuant to the Court's SLA. Accordingly, the fifteen (15) licenses transfer to the Clerk at no cost to the Court, Clerk, or Board. equivant shall not charge or invoice the Court, Clerk, or Board for any license fees for the fifteen (15) licenses transferred from the Court to the Clerk;
6. As of the Effective Date, the parties agree:
    a. The Court shall no longer have any obligations, duties, and/or responsibilities; including software maintenance and support, for the fifteen (15) licenses transferred from the Court to the Clerk; and,
    b. The Court relinquishes all benefits and rights attendant to the fifteen (15) licenses transferred from the Court to the Clerk; and,
    c. The Clerk shall have all benefits and rights attendant to the fifteen (15) licenses transferred from the Court to the Clerk; and,
    d. The Clerk shall assume all obligations, duties, and/or responsibilities, including software maintenance and support, for the fifteen (15) licenses transferred from the Court to the Clerk;
7. Any person executing this Amendment 1 in a representative capacity hereby warrants that he/she has authority to sign this Amendment 1 or has been duly authorized by his/her principal to execute this Amendment 1 on such principal's behalf and is authorized to bind such principal;
8. The parties will enter into a new SOFTWARE MAINTENANCE AGREEMENT (SMA) reflecting the reduced license count. The terms and conditions of the new SMA shall in no way alter or modify the SLA and will not have any effect on the terms and conditions of the SLA and this Amendment 1;
9. The rest of the terms and conditions of the SLA not changed by this Amendment 1 shall stand unaffected and shall continue in full force and effect;
10. This Amendment 1 will be given priority in case of any conflict between the provisions of the SLA and this Amendment 1;
11. This Amendment is agreed upon and fully executed by the undersigned parties.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have entered into this Amendment 1.

AMENDMENT 1
SOFTWARE LICENSE AGREEMENT

This AMENDMENT 1 SOFTWARE LICENSE AGREEMENT ("Amendment 1") amends the SOFTWARE LICENSE AGREEMENT ("SLA") dated October 7, 2010 between CourtView Justice Solutions Inc. d/b/a equivant ("equivant"), a Delaware Corporation, with offices at 4825 Higbee Ave NW, Canton, OH 44718, and the Board of Commissioners, Delaware County, Ohio ("Board") whose principal offices are located at 101 North Sandusky Street, Delaware, Ohio 43015 on behalf of the Delaware County Juvenile and Probate Court ("Court"), with offices at 140 North Sandusky Street, Ground Floor, Delaware, Ohio 43015.

IN CONSIDERATION OF the parties agreeing to amend their obligations in the existing SLA, the mutual benefits derived from this Amendment 1 and other valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to keep, perform and fulfill the promises, conditions and agreements below.

1. The SLA is amended to reduce the total license count for the Court with respect to the CourtView Case Management System ("CourtView CMS") and CourtView Dashboard from a total of seventy (70) licenses to a total of fifty-five (55) licenses;
2. A total of fifteen (15) licenses held by the Court under the original SLA are transferred from the Court to the Clerk of Courts of the Delaware County Common Pleas Court ("Clerk");
3. As a result of such transfer, the total license count of licenses held by the Court under the SLA is reduced from a total of seventy (70) licenses to a total of fifty-five (55) licenses effective the date the last party signs this Amendment 1 ("Effective Date");
4. The license counts in the SLA Schedule 1 – Software License(s) and Fee(s) ("Schedule 1") shall be changed as of the Effective Date to reduce the number of licenses held by the Court to a total of fifty-five (55) licenses for CourtView CMS and CourtView Dashboard. The license count shall be similarly changed in any and all other locations in Schedule 1 where a license count appears;
5. License counts held by the Court that appear anywhere else in the SLA and/or any attachment to the SLA shall be changed as of the Effective Date to the reduced license count of a total of fifty-five (55) licenses;
6. All license fees for the seventy (70) licenses originally included in the SLA have to-date been paid in-full, including the license fees for the fifteen (15) transferred licenses. Accordingly, the fifteen (15) licenses transfer to the Clerk at no cost to the Court, Clerk, or Board. equivant shall not charge or invoice the Court, Clerk, or Board for any license fees for the fifteen (15) licenses transferred from the Court to the Clerk;
7. As of the Effective Date, the parties agree:
    a. All obligations and benefits; rights and duties; including software maintenance and support for the fifteen (15) licenses will be transferred from the Court to the Clerk; and,
    b. The Court shall no longer have any obligations, duties, and/or responsibilities; including software maintenance and support, for the fifteen (15) licenses transferred from the Court to the Clerk; and,
    c. The Court relinquishes all benefits and rights attendant to the fifteen (15) licenses transferred from the Court to the Clerk; and,
    d. The Clerk will be responsible for any expenses and payments for the software maintenance and support in regard to the transferred fifteen (15) licenses;

8. The parties will enter into a new SOFTWARE MAINTENANCE AGREEMENT (SMA) reflecting the reduced license count. The terms and conditions of the new SMA shall in no way alter or modify the SLA and will not have any effect on the terms and conditions of the SLA and this Amendment 1;
9. The rest of the terms and conditions of the SLA not changed by this Amendment 1 shall stand unaffected and shall continue in full force and effect;
10. This Amendment 1 shall be given priority in case of any conflict between the provisions of the SLA and this Amendment 1;
11. Any person executing this Amendment 1 in a representative capacity hereby warrants that he/she has authority to sign this Amendment 1 or has been duly authorized by his/her principal to execute this Amendment 1 on such principal's behalf and is authorized to bind such principal.
12. This Amendment is agreed upon and fully executed by the undersigned parties.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have entered into this Amendment 1.

Vote on Motion Mrs. Lewis Aye Mr. Benton Absent Mr. Merrell Aye

7
RESOLUTION NO. 18-125

IN THE MATTER OF APPROVING THE SOFTWARE MAINTENANCE AGREEMENT BETWEEN THE BOARD OF DELAWARE COUNTY COMMISSIONERS, THE DELAWARE COUNTY JUVENILE AND PROBATE COURT, AND COURTVIEW JUSTICE SOLUTIONS INC. D/B/A EQUIVANT:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

Whereas, the County Juvenile Court and Staff recommend approval of the software maintenance agreement between the Board Of Delaware County Commissioners, The Delaware County Juvenile and Probate Court, and CourtView Justice Solutions Inc. d/b/a equivant;

Therefore Be It Resolved, That The Delaware County Board Of Commissioners approve the software maintenance agreement between The Board Of Delaware County Commissioners, The Delaware County Juvenile and Probate Court, and CourtView Justice Solutions Inc. d/b/a equivant:

SOFTWARE MAINTENANCE AGREEMENT

This Software Maintenance Agreement ("Agreement") is entered into as of February 8, 2018 by and between CourtView Justice Solutions Inc. d/b/a equivant, with offices at 4825 Higbee Avenue NW, Suite 101, Canton, Ohio 44718 ("equivant"), and the Board of Commissioners, Delaware County, Ohio ("Board"), whose principal offices are located at 101 North Sandusky Street, Delaware, Ohio 43015 on behalf of the Delaware County Juvenile and Probate Court ("Court"), with offices located at 140 North Sandusky Street, Ground Floor, Delaware, Ohio 43015 (Board and Court collectively "Customer"), and describes the terms and conditions pursuant to which equivant shall provide software maintenance services to Customer for certain Software (as defined below) (equivant and Customer collectively "Parties," individually "Party").

Whereas, equivant and Customer are parties to a Software License Agreement pursuant to which Customer has licensed certain software products ("Software") from equivant. Software expressly excludes software licensed by a third party;

Whereas, the Software paid-up license fee includes a warranty without charge as set forth in the Software License Agreement. In addition, support and maintenance ("Maintenance") for the Software is available. Maintenance includes bug fixes and telephone support and may include, if they are made available by equivant, software updates and enhancements; and

Whereas, the parties wish to set forth the terms and conditions upon which the Parties have agreed Maintenance will be provided by equivant to the Customer for the Software. Except as expressly provided in this Agreement, equivant does not provide Maintenance for third party software that is licensed by a party other than equivant.

Therefore intending to be legally bound, the Parties hereby mutually agree to the following terms:

1. **TERM**

   Maintenance provided under this Agreement commenced on November 1, 2017, however, this Agreement shall be effective upon the date the last Party signs this Agreement ("Effective Date") and shall continue through December 31, 2020 ("Initial Term").

2. **RENEWAL**

   Upon written agreement of the Parties, this Agreement may be renewed for additional one (1) year periods ("Subsequent Term") subject to the same terms and conditions provided herein and upon any such terms and

conditions as may be specifically agreed upon, added and/or amended in writing by the Parties, unless terminated as set forth below.

3. **SCOPE OF MAINTENANCE SERVICES**

The Parties agree and understand that the fully executed Amendment 1 to the SOFTWARE LICENSE AGREEMENT transferring 15 licenses from the Court to the Clerk of Courts of the Delaware County Common Pleas Court is a condition precedent to the execution and implementation of this SOFTWARE MAINTENANCE AGREEMENT.

equivant will provide the Maintenance as described in the Maintenance Terms attached hereto and labeled as Exhibit A.

equivant will provide tier one support for third party software purchased from equivant, tier two and three support and revisions and upgrades will be provided by the manufacturer of such third party software. Tier one, tier two and tier three support is defined as:

> **Tier I:** Is the initial support level responsible for basic customer reported issues. It is synonymous with first line support and denotes use support. A Tier I (equivant) customer care specialist will gather the customer's information and determine the customer's issue by analyzing the symptoms and will attempt to identify the root cause of the underlying problem. If the root cause is a basic use issue the assigned customer care specialist will attempt to remediate the issue before escalating the issue to a higher level. If the reported issue is a technical issue the assigned customer care specialist will escalate the issue to a higher level.
>
> **Tier II:** This is a more in-depth technical support level provided by personnel with additional experience and knowledge of the product. Manufacturer technicians providing Tier II support are responsible for: helping Tier I customer care specialist solve basic use problems, for handling basic technical issues, for investigating escalated issues by confirming the validity of the reported issue and identifying known solutions related to these more complex issues. If an issue is new and/or the assigned technician cannot determine a solution, they are responsible for escalating this issue to the Tier III technical support group.
>
> **Tier III:** This is the highest level of technical support and is provided by manufacturer technicians with extensive experience and knowledge of the product for handling the most difficult and advanced problems. Often the Tier III technical support group includes the staff that developed and tested the product.

4. **PROPRIETARY PROPERTY**

All software development, design, documentation, and programs necessary to operate and maintain the systems described herein that were produced by equivant shall remain the proprietary property of equivant. Restriction of this proprietary property does not limit the Customer from making such copies of programs, documentation, and software-related materials for internal use. Except as otherwise required by law, disclosure of such materials to third parties or other contractors is strictly forbidden without the express written consent of equivant.

5. **CUSTOMER RESPONSIBILITY FOR ENVIRONMENT**

To operate the supported software, equivant will provide Customer with a definition of minimum requirements for the Customer's environment, infrastructure and related applications, which include, but are not limited to, Customer's operating system, database tools, and other support tools. equivant will provide Customer with at least ninety (90) days written notice of changes to those minimum requirements. Customer must meet those minimum requirements or equivant may decline to provide Maintenance. equivant has no obligation to upgrade the supported software because of Customer's changes to its environment, infrastructure and related applications, including, but are not limited to, Customer's operating system, database tools and other supported tools.

6. **SOFTWARE MAINTENANCE FEE – PAID UP LICENSE**

In consideration of the Maintenance services to be provided for the Initial Term, Customer shall pay to equivant the applicable amount set forth in the Software Maintenance Fee Schedule attached hereto as Schedule 1. For each Subsequent Term, equivant reserves the right to change the annual Maintenance fee by providing Customer written notice of the change at least forty-five (45) days prior to the start date of any Subsequent Term.

7. **CONTRACT MAXIMUM**

It is expressly understood and agreed that the total amount to be paid under this Agreement shall not exceed the maximum of $131,011.50.

8. **ADDITIONAL SOFTWARE – PAID UP LICENSE**

In the event the Customer requires maintenance for additional Software ("Additional Software"), the parties may mutually agree in writing to modify this Agreement to include the Additional Software on Schedule 1 and make any other changes necessary for coverage of the Additional Software hereunder. The Software Maintenance Fee due under this Agreement shall also be modified in writing to include a prorated amount of the annual maintenance fee for the Additional Software covering the term remaining under then current term of this Agreement. The Maintenance Fee for this initial period of coverage shall be in an amount equal to twenty two percent (22%) of the non-discounted license fee paid for the Additional Software. For the first Subsequent Term, the amount due for the Additional Software shall be of the full value of the 22% of the non-discounted cost of the license fee. Thereafter, any change in the amount of annual Maintenance Fee due shall be provided as set out in this Agreement

9. **OTHER FEES AND EXPENSES**

Onsite Maintenance shall be provided only upon request by the Customer. If onsite maintenance is requested, Customer shall reimburse equivant for reasonable travel expenses of equivant's employees or agents in providing the onsite Maintenance, including meals during the period of travel. Reimbursement shall be limited to those items that are reimbursable under the then current Delaware County Employee Travel and Expense Reimbursement Policy, capped at the rates for reimbursement listed in such Policy. Travel expenses shall be billed and paid as the expenses are incurred. Onsite labor shall be provided on an hourly rate basis at the then current rates. Reimbursed travel expenses shall be invoiced and paid in the same manner as Maintenance.

10. **PAYMENT TERMS**

a. To receive payment, equivant shall submit proper annual invoices to the Court. Invoices shall be submitted to:

Karen Wadkins
Fiscal Coordinator
Delaware County Juvenile and Probate Courts
140 North Sandusky St., Ground Floor
Delaware, Ohio 43015

b. A proper invoice shall be on company letterhead and clearly display the word "Invoice" and include a sequential invoice number. Invoices shall be itemized and show a detail of all Maintenance and/or services to be provided and all other fees and costs.

c. Payment for Maintenance for initial and subsequent terms is due and payable within thirty (30) days of the date of receipt by the Court of each proper invoice. The date of the warrant issued in payment shall be considered the date payment is made.

d. Payment shall not be initiated by the Customer before a proper invoice is received. Defective invoices shall be returned to equivant noting deficiencies and areas for correction. When such notification of defect is sent, the required payment date shall be thirty (30) days after receipt by the Customer of a corrected and proper invoice.

e. If a proper invoice remains unpaid by the Customer for at least ninety (90) days after receipt by the Customer, equivant may suspend Maintenance. Any such suspension shall occur only upon thirty (30) days advance written notice to Customer of the intent to suspend Maintenance. Reinstatement of Maintenance following such suspension requires all overdue payments to be paid in full.

f. equivant reserves the right after the Court has received an invoice to apply a late payment charge of 1.5% per month to amounts outstanding more than thirty (30) days after the payment due date shown on the invoice.

11. **DEFAULT AND TERMINATION**

a. The Customer shall have the right to terminate Maintenance upon delivery of written notice to equivant at least thirty (30) days prior to the start date of any Subsequent Term.

b. The parties may mutually agree in writing to terminate this Agreement.

c. Either party may terminate this Agreement if: (i) the other party fails to perform a material obligation of this Agreement, and if such failure remains uncured 30 days after receipt of written notice from the non-breaching party specifying the failure; or (ii) a party ceases to conduct business, becomes or is declared insolvent or bankrupt, is the subject of any proceeding relating to its liquidation or insolvency which is not dismissed within 90 days or makes an assignment for the benefit of creditors.

d. equivant may terminate this Agreement if a proper invoice remains unpaid by the Customer for at least ninety (90) days after receipt by the Customer. Such termination shall be effective upon thirty (30) days advance written notice to Customer and only if the Customer does not cure within thirty (30) days.

e. In the event that Maintenance is terminated by equivant pursuant to this section, equivant shall have no continuing obligations to the Customer of any nature whatsoever with respect to Maintenance. Furthermore, termination by equivant pursuant to the provisions hereof shall be without prejudice to any right or recourse available to equivant, and without prejudice to equivant's right to collect any amounts, which remain due to it hereunder.

f. The Parties, without limitation, retain and reserve and may exercise any available administrative, contractual, equitable or legal actions or remedies.

12. **LIMITED WARRANTIES**

a. Software. equivant warrants for a period of ninety (90) days following the date of delivery of any software under this Agreement that it will substantially operate according to the documentation and product literature provided by equivant. If it is determined solely by Customer that the software does not substantially operate according to such documentation provided by equivant, equivant shall, at its option and expense, apply commercially reasonable efforts to designing, coding and implementing programming changes to the source code to correct reproducible errors or correcting misstatements and omissions in the User's Guide and code documentation. Customer shall report all errors or other defects in the software to equivant immediately upon their discovery. The remedies set forth in this section constitute Customer's sole and exclusive remedy for breach of this Warranty. equivant does not warrant Third Party Software. equivant will transfer any warranty provided by the licensor of the Third Party Software to Customer. Third Party Software is software that is not proprietary to equivant.

b. Services. equivant warrants that the Services provided under this Agreement shall be performed with that degree of skill and judgment normally exercised by recognized professional firms performing the same or substantially similar services. In the event of any breach of the foregoing warranty, provided Customer has delivered to equivant timely notice of such breach as hereinafter required, equivant shall, at its own expense, in its discretion either (1) re-perform the non-conforming Services and correct the non-conforming Deliverables to conform to this standard; or (2) refund to Customer that portion of the Price received by equivant attributable to the non-conforming Services and/or Deliverables. No warranty claim shall be effective unless Customer has delivered to equivant written notice specifying in detail the non-conformities within 90 days after performance of the non-conforming Services or tender of the non-conforming Deliverables. The remedy set forth in this section is the sole and exclusive remedy for breach of the foregoing warranty.

c. **NO OTHER WARRANTIES. EQUIVANT MAKES NO OTHER WARRANTIES, WHETHER EXPRESS, IMPLIED, OR STATUTORY REGARDING OR RELATING TO THE SOFTWARE OR THE DOCUMENTATION, OR ANY MATERIALS OR SERVICES FURNISHED OR PROVIDED TO CUSTOMER UNDER THIS AGREEMENT, INCLUDING MAINTENANCE AND SUPPORT. EQUIVANT SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE WITH RESPECT TO THE SOFTWARE, DOCUMENTATION AND SAID OTHER MATERIALS AND SERVICES, AND WITH RESPECT TO THE USE OF ANY OF THE FOREGOING.**

13. **LIMITATION OF LIABILITY**

a. Customer hereby agrees that equivant's total liability to Customer for any and all liabilities, claims or damages arising out of or relating to this Agreement, howsoever caused and regardless of the legal theory asserted, including breach of contract or warranty, tort, strict liability, statutory liability or otherwise, shall not, in the aggregate, exceed fees paid to equivant hereunder. The parties acknowledge and agree to the foregoing liability risk allocation. Any claim by Customer against equivant relating to this Agreement must be made in writing and presented to equivant within six (6) months after the date on which this Agreement expires or is otherwise terminated.

b. In no event shall either party be liable to the other for any punitive, exemplary, special, indirect, incidental or consequential damages (including, but not limited to, lost profits, lost business opportunities, loss of use or equipment down time, and loss of or corruption to data) arising out of or relating to this Agreement, regardless of the legal theory under which such damages are sought, and even if the parties have been advised of the possibility of such damages or loss and notwithstanding any failure of essential purpose of any limited remedy.

14. **INDEMNITY**

a. equivant agrees to defend, indemnify, and hold harmless the Court, the Board, Delaware County, Ohio, and all of their respective boards, officers, officials, employees, volunteers, agents, and representatives

(collectively "Indemnified Parties") from and against any and all third party actions, claims, suits, and/or demands and any judgments, awards, damages, losses, costs, fines, penalties, fees, and expenses resulting therefrom, including, but not limited to attorney's fees, as well as the reasonable costs related thereto (hereinafter collectively referred to as "Damages"), to the extent such Damages result from the gross negligence or willful acts or omissions of equivant or any of its boards, officers, officials, employees, volunteers, agents, and representatives occurring in the performance of equivant's obligations hereunder; provided, such defense and payments are conditioned on the following: (1) that equivant shall be notified in writing by Customer within 10 business days following its receipt of any such claim, and (2) that equivant shall have sole control of the defense of any action on such claim and all negotiations for its settlement or compromise. equivant shall not be responsible for any Damages or liability resulting, in whole or in part, from the negligence or willful misconduct of the Indemnified Parties.

b. equivant shall assume full responsibility for, pay for, and shall indemnify and hold free and harmless the Indemnified Parties from any harm, damage, destruction, injury, or loss, regardless of type or nature, known or unknown, realized or unrealized, to any property, real or personal, belonging to the Indemnified Parties or others, including but not limited to real estate, buildings, structures, fixtures, furnishings, equipment, vehicles, supplies, accessories and/or parts arising out of or resulting in whole or in part from any actions, inactions, or omissions negligent or accidental, actual or threatened, intentional or unintentional of equivant or any of its boards, officers, officials, employees, volunteers, agents, and representatives

15. **INSURANCE**

equivant shall carry and maintain throughout the term of the Agreement, without lapse, the following policies of insurance with the following minimum coverage limits.

a. Commercial General Liability Insurance with minimum coverage limits of at least one million dollars ($1,000,000.00) per occurrence, with an annual aggregate of at least two million dollars ($2,000,000.00), including coverage for subcontractors, if any are used. This insurance shall include, but not be limited to, the following coverage:

1. Premises-Operations
2. Product and Completed Operation
3. Broad Form Property Damage
4. Contractual
5. Personal Injury

b. Umbrella or Excess Liability Insurance (over and above Commercial General Liability) with minimum coverage limits of at least two million dollars ($2,000,000.00).

c. If vehicles are to be used by equivant in connection with this Agreement, Auto/Vehicle Liability Insurance covering all owned, leased, non-owned, and/or hired vehicles so used with minimum coverage limits at least three hundred thousand dollars ($300,000.00) (Combined Single Limit) or, one hundred thousand dollars ($100,000.00) per person and three hundred thousand dollars ($300,000.00) per accident for bodily injury and one hundred thousand dollars ($100,000.00) per accident for property damage or more as may be required for particular vehicles or particular uses of vehicles as required by applicable law.

Prior to commencement of this Agreement, equivant shall present to the Customer current certificates of insurance for the above required policies of insurance. The insurance company needs to be identified for each insurance policy and coverage. The certificates of insurance are to be signed by a person authorized by the insurance company to bind coverage on its behalf.

The Customer and Delaware County, Ohio shall be named as "Additional Insured" on the above listed policies of insurance.

equivant shall be responsible for any and all premiums for all required policy(ies) of insurance.

All insurance shall be written by insurance companies licensed to do business in the State of Ohio and in good standing with the Ohio Department of Insurance.

The above required insurance coverage shall be primary insurance in respect to the Customer and any insurance maintained by the Customer shall be excess to the above required insurance and shall not contribute to it.

The insurer shall provide thirty (30) days written notice to the Customer before any cancellation or non-renewal of insurance coverage. Failure to provide such written notice will obligate the insurer to provide coverage as if cancellation or non-renewal did not take place.

If there is any change in insurance carrier or liability amounts, a new certificate of insurance must be provided

to the Customer within seven (7) calendar days of change.

During the life of the Agreement, the Customer may request and equivant shall timely produce additional certificate(s) of insurance. Failure of equivant to provide a requested certificate of insurance within seven (7) calendar days of the request may be considered as default.

In addition to the rights and protections provided by the insurance policies as required above, the Customer shall retain any and all such other and further rights and remedies as are available at law or in equity.

16. **WORKERS COMPENSATION INSURANCE**

equivant shall carry and maintain throughout the term of the Agreement Worker's Compensation Insurance as required by Ohio law and any other state in which work will be performed. equivant shall be responsible for any and all premiums for such policy(ies). At any time throughout the life of the Agreement the Customer may request proof of such insurance. Proof of such insurance shall be promptly provided upon request.

17. **LICENSES**

equivant certifies and warrants that it and/or its employees have obtained and maintain current all approvals, licenses, including operator licenses, certifications, and/or other qualifications (collectively "Licenses") necessary and/or required by law to perform this Agreement and to conduct business in the state of Ohio. equivant further certifies and warrants that all such Licenses are operative and current and have not been revoked or are not currently suspended for any reason.

18. **CERTIFICATION REGARDING FINDINGS FOR RECOVERY**

equivant, by signature of its authorized representative below, hereby certifies that it is not subject to any current unresolved findings for recovery pending or issued against it by the State of Ohio.

____
Signature

____
Title

19. **CERTIFICATION REGARDING PERSONAL PROPERTY TAXES**

equivant, by signature of its authorized representative below, hereby certifies that it is not charged with delinquent personal property taxes on the general list of personal property in Delaware County, Ohio, or any other counties containing property in the taxing districts under the jurisdiction of the Auditor of Delaware County, Ohio.

____
Signature

____
Title

20. **INDEPENDENT CONTRACTOR**

equivant agrees that it shall act in performance of this Agreement as an independent contractor. No agency, employment, joint venture, or partnership has been or will be created between the Parties hereto pursuant to the terms and conditions of this Agreement.

equivant assumes all responsibility for any and all federal, state, municipal, or other tax liabilities, along with workers compensation, unemployment compensation, contributions to retirement plans, and/or insurance premiums which may accrue and/or become due as a result of compensation received for services and/or deliverables rendered and/or received under or pursuant to this Agreement.

equivant and/or its officers, officials, employees, representatives, agents, and/or volunteers are not entitled to any benefits enjoyed by employees of the Court, the Board, or Delaware County, Ohio.

21. **INDEPENDENT CONTRACTOR ACKNOWLEDGEMENT/ NO CONTRIBUTION TO OPERS**

The Court, the Board, and Delaware County, Ohio (for purposes of this section collectively "County") are public employers as defined in R.C. § 145.01(D). The County has classified equivant as an independent contractor or another classification other than public employee. As a result, no contributions will be made to the Ohio Public Employees Retirement System ("OPERS") for or on behalf of equivant and/or any of its officers, officials, employees, representatives, agents, and/or volunteers for services and/or deliverables

rendered and/or received under or pursuant to this Agreement. equivant acknowledges and agrees that the County, in accordance with R.C. § 145.038(A), has informed it of such classification and that no contributions will be made to OPERS. If equivant is an individual or has less than five (5) employees, equivant, in support of being so informed and pursuant to R.C. § 145.038, agrees to and shall complete and shall have each of its employees complete an OPERS Independent Contractor Acknowledgement Form ("Form"). The Form is attached hereto as Exhibit B. The Court shall retain the completed Form(s) and immediately transmit a copy(ies) of it/them to OPERS.

If equivant has five (5) or more employees, equivant, by signature of its authorized representative below, hereby certifies such fact in lieu of completing the Form:

____
Signature

____
Title

22. **CAMPAIGN FINANCE – COMPLIANCE WITH R.C. § 3517.13**

Ohio Revised Code Section 3517.13 (I)(3) and (J)(3) require that no political subdivision shall award any contract for the purchase of goods with a cost aggregating more than ten thousand dollars in a calendar year or services with a cost aggregating more than ten thousand dollars in a calendar year to a corporation, business, trust, individual, partnership or other unincorporated business, association, including, without limitation, a professional association organized under Chapter 1785 of the Revised Code, estate, or trust unless the political subdivision has received for that calendar year, or the contract includes, a certification that the individuals named in said sections of the Revised Code are in compliance with the applicable provisions of R.C. § 3517.13. equivant, therefore, is required to complete the attached certificate/affidavit entitled "Certification/Affidavit in Compliance With O.R.C. Section 3517.13." Failure to complete and submit the required aforementioned certificate/affidavit with the Agreement will prohibit the Customer from entering, proceeding with, and/or performing the Agreement. Such certification is attached to this Agreement as Exhibit C.

23. **ACCESS TO RECORDS**

With reasonable notice to equivant, and as often as the Customer or other agency or individual authorized by the Customer may deem necessary, equivant shall make available to any or all the above named parties or their authorized representatives, at no cost and within a reasonable period of time, any and/or all contracts, subcontracts, invoices, receipts, reports, and documents, covered by this Agreement ("Records"). The Customer and the above named parties shall be permitted by equivant and shall be entitled to inspect or audit and/or make excerpts, photocopies, and/or transcripts of the Records.

24. **RETENTION OF RECORDS**

For a minimum of three (3) years after reimbursement/compensation for services rendered under this Agreement, equivant shall retain and maintain, and assure that all of its subcontractors retain and maintain, all Records. If an audit, litigation, or other action is initiated during the term of this Agreement, equivant shall retain and maintain, and assure that all of its subcontractors retain and maintain, the Records until the action is concluded and all issues are resolved or the three (3) years have expired, whichever is later.

25. **AUDITS**

equivant agrees to fully cooperate with any audit of expenditures and/or records of service delivery conducted in association with this Agreement. equivant agrees to accept responsibility for receiving, replying to, and/or complying with any audit exception by any appropriate federal, state, local, or independent audit authority that is in any way associated with this Agreement and is attributable to equivant or the Maintenance. equivant agrees to reimburse the Customer the amount of any such audit exception, but only limited to resulting from overpayment by Customer.

26. **EQUAL OPPORTUNITY/NON-DISCRIMINATION/CIVIL RIGHTS**

In fulfilling the obligations and duties of this Agreement, equivant certifies and agrees as follows:

a. equivant, all subcontractors, and/or any person acting on behalf of equivant or any subcontractor shall comply with any and all applicable federal, state, and/or local laws prohibiting discrimination and providing for equal opportunity.

b. equivant, all subcontractors, and/or any person acting on behalf of equivant or any subcontractor shall not in any way or manner discriminate on account of race, color, religion, sex, age, disability,

handicap, sexual orientation, gender identity, or military status as defined in R.C. § 4112.01, national origin, or ancestry.

equivant shall ensure that applicants are hired and that employees are treated during employment without regard to any of the above listed factors. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation and selection for training, including apprenticeship.

equivant agrees to post in conspicuous places, available to employees and applicants for employment, notices stating that equivant complies with all applicable federal and state non-discrimination laws.

equivant shall incorporate the foregoing requirements of this section in all of its contracts for any of the work prescribed herein, and shall require all of its subcontractors for any part of such work to incorporate such requirements in all subcontracts for such work.

27. **COUNTY POLICY**

equivant shall be bound by, conform to, comply with, and abide by all current applicable Delaware County policies, including, but not limited to, the Contractor Safety Policy, Computer Use Policy, Social Media Policy, and Internet Use Policy (collectively "County Policy") and shall require any and all of its boards, board members, officers, officials, employees, representatives, agents, subcontractors, and/or volunteers performing work under this Agreement and/or for or on behalf of the County to comply with County Policy and shall be responsible for such compliance. The County may, in its sole discretion, immediately terminate this Agreement for failure of equivant or any of its employees or subcontractors to comply with County Policy. Copies of County Policy are available upon request or online at http://www.co.delaware.oh.us/index.php/policies. The County reserves the authority to change, amend, replace, enact, repeal, and/or rescind County Policy at any time and without notice.

28. **DRUG FREE/SMOKE FREE ENVIRONMENT**

equivant agrees to comply with all applicable federal, state, and local laws regarding drug-free and smoke-free workplaces and environments. equivant shall make a good faith effort to ensure that all of its employees and subcontractors engaged in the work being performed hereunder will not purchase, transfer, use, or possess illegal drugs or alcohol, or abuse prescription drugs in any way.

29. **TERMINATION OF PRIOR SOFTWARE MAINTENANCE AGREEMENT**

The Parties hereby agree that the Software Maintenance Agreement between the Parties on behalf of the Court dated October 7, 2010 and all other prior Software Maintenance Agreements between the Parties on behalf of the Court are hereby terminated as of the Effective Date.

30. **GENERAL TERMS**

a. Neither Party may sell, assign, transfer, or otherwise convey any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other Party, except in the event of sale of assets, merger or consolidation. Notwithstanding the foregoing, equivant may without violation of this paragraph engage the services of independent contractors to assist in the performance of its duties hereunder.

b. All provisions of this Agreement, which by their nature should survive termination of this Agreement, will so survive.

c. Any waiver of the provisions of this Agreement or of a Party's rights or remedies under this Agreement must be in a signed writing to be effective. Delay or failure by either Party to exercise any right hereunder, or to enforce any provision of this Agreement will not be considered a waiver thereof and will not in any way affect the validity of the whole or any part of this Agreement or prejudice such Party's right to take subsequent action. No single waiver will constitute a continuing or subsequent waiver, nor shall a waiver of any one provision of the Agreement be deemed to be a waiver of any other provision.

d. If any provision of the Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any manner. If any term, condition or provision in this Agreement is held to be illegal, invalid or unenforceable, in whole or in part, the Parties shall work in good faith to agree to such modification that will to the maximum extent possible preserve the original intention of said term, condition or provision. If the Parties fail to agree on such an amendment, such invalid term, condition or provision will be severed from the remaining terms, conditions and provisions, which will continue to be valid and enforceable to the fullest extent permitted by law.

e. This Agreement shall be governed by the laws of the State of Ohio, without regard to its laws relating to conflict or choice of laws. Subject to Paragraph g. below, the parties agree that the sole jurisdiction and venue for actions related to the subject matter hereof shall be the state and U.S. Federal courts in the State

of Ohio. Both parties consent to the jurisdiction of such courts and waive any objections regarding venue in such courts.

f. Any communication or notice permitted under the terms of this Agreement or required by law must be in writing, and will be deemed given and effective: (i) when delivered personally with proof of receipt; (ii) when sent by e-mail; (iii) when delivered by overnight express; or (iv) when mailed by certified or registered mail, postage prepaid, return receipt requested and addressed to a Party at its address for notices. Each Party's address for notices is stated below. Such address may be changed by a notice delivered to the other Party in accordance with the provisions of this Section.

Customer
Judge David. A. Hejmanowski
Delaware County Juvenile & Probate Court
140 North Sandusky Street
Delaware, Ohio 43015
DHejmanowski@co.delaware.oh.us

equivant
General Manager
equivant
4825 Higbee Avenue NW
Suite 101
Canton, Ohio 44718
Tel. No. 330.470.4280

Fax No. 330.494.2483
Email: ________________________

Copy to:
Christopher D. Betts
Delaware County Prosecutor's Office
140 N. Sandusky Street
3rd Floor
Delaware, Ohio 43015
CBetts@co.delaware.oh.us

Copy to:
Contract Manager

equivant
4825 Higbee Avenue NW
Suite 101
Canton, Ohio 44718
Email: ________________________

g. The Parties will work together to resolve any disputes involving this Agreement and shall seek a fair and prompt negotiated resolution within ten (10) days of the initial notice of a dispute ("Dispute"). If the Dispute has not been resolved after such time, the Parties will escalate the issue to more senior levels. If the Parties are unable to resolve any Dispute at the senior management level, then the Parties retain and may, without limitation, exercise any and all available administrative, contractual, equitable or legal remedies.

h. Neither Party shall be liable for any failure of or delay in performance of its obligations (except for payment obligations) under this Agreement to the extent such failure or delay is due to acts of God, acts of a public enemy, fires, floods, power outages, wars, civil disturbances, epidemics, pandemics, sabotage, terrorism, accidents, insurrections, blockades, embargoes, storms, explosions, labor disputes (whether or not the employees' demands are reasonable and/or within the Party's power to satisfy), failure of common carriers, Internet Service Providers, or other communication devices, acts of cyber criminals, terrorists or other criminals, acts of any governmental body (whether civil or military, foreign or domestic), failure or delay of third parties or governmental bodies from whom a Party is obtaining or must obtain approvals, authorizations, licenses, franchises or permits, inability to obtain labor, materials, power, equipment, or transportation, or other circumstances beyond its reasonable control (collectively referred to herein as "Force Majeure Occurrences"). Any such delays shall not be a breach of or failure to perform this Agreement or any part thereof and the date on which the obligations hereunder are due to be fulfilled shall be extended for a period equal to the time lost as a result of such delays.

i. This Agreement and any Schedules or Exhibits attached thereto contain the entire agreement and understanding between the parties with respect to the subject matter hereof and supersedes any and all prior or contemporaneous proposals, discussions, agreements, Customer issued purchase order or document of like intent or purpose, understandings, commitments, representations of any kind, whether oral or written, relating to the subject matter hereof. It is expressly agreed that if Customer issues a purchase order or other document for the services provided under this Agreement, such instrument will be deemed for Customer's internal use only, and no terms, conditions or provisions contained therein shall have any effect on the rights, duties or obligations of the Parties under, or in any way modify, this Agreement, regardless of any failure by equivant to object to such terms, conditions or provisions. This Agreement sets forth the sole and entire understanding between equivant and Customer with respect to the subject matter.

j. The following exhibits are attached to this Agreement and by this reference incorporated into and made a part of this Agreement:

- Schedule 1 – Software Maintenance Fee Schedule
- Exhibit A – Maintenance Terms
- Exhibit B – OPERS Independent Contractor Acknowledgement Form

- Exhibit C - Certification/Affidavit in Compliance With O.R.C. Section 3517.13

k. Delaware County, Ohio is a political subdivision and tax exempt. equivant shall not charge the Customer any tax and agrees to be responsible for all tax liability that accrues as a result of this Agreement and the Services provided pursuant to this Agreement. Proof of exemption shall be provided upon request.

l. Consistent with R.C. § 307.86(B)(2), the purchase consists of services related to information technology, such as programming services, that are proprietary or limited to a single source. As a result, this Contract is not required to be competitively bid.

m. This Agreement may only be amended in writing with the mutual consent and agreement of the parties.

n. The subject headings of the paragraphs in this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

o. This Agreement may be executed in counterparts.

p. This Agreement shall be deemed to have been drafted by both equivant and the Customer and no purposes of interpretation shall be made to the contrary.

q. Any person executing this Agreement in a representative capacity hereby warrants that he/she has authority to sign this Agreement or has been duly authorized by his/her principal to execute this Agreement on such principal's behalf and is authorized to bind such principal.

SCHEDULE 1

SOFTWARE MAINTENANCE FEE SCHEDULE

Delaware County Juvenile and Probate Court					
		2017	**2018**	**2019**	**2020**
	License	11/1/17 to 12/31/17	1/1/18 to 12/31/18	1/1/19 to 12/31/19	1/1/20 to 12/31/20
Juvenile / Probate Court					
CourtView CMS	50	$5,584.00	$34,508.00	$35,543.00	$36,609.00
*Banked CourtView CMS	5	$167.50	$1,035.00	$1,066.00	$1,098.00
CourtView Dashboards	55	$766.00	$4,735.00	$4,877.00	$5,023.00
Total		**$6,517.50**	**$40,278.00**	**$41,486.00**	**$42,730.00**

BANKED LICENSES

*The Customer has requested to temporarily deactivate or "bank" five (5) ("Banked Licenses") CourtView licenses, thereby reducing the total active CourtView licenses from fifty-five (55) to fifty (50) beginning November 1, 2017. The Customer understands that they will not be able to use the Banked Licenses unless reactivated.

equivant agrees to reduce the annual maintenance fee for the Banked Licenses by 70% of the annual maintenance fee for the active licenses for the annual maintenance period beginning November 1, 2017. For subsequent annual maintenance periods, equivant will continue to recognize fifty (50) active licenses and bank the five (5) licenses for subsequent maintenance years upon timely payment of current maintenance fees less 70% for the banked licenses. Annual fee increases shall apply to both active and Banked Licenses.

Provided that payment for the Banked Licenses is received, as detailed above, equivant will pay the support and maintenance of the third party Uniface licenses for the Banked Licenses so that the County will not incur reactivation costs from the third party, Uniface, when they reactivate the Banked Licenses.

Upon receipt of written request and full payment of the then current annual maintenance fee equivant will reactivate the Banked Licenses. The maintenance fee will be prorated into the current maintenance schedule, if applicable.

Exhibit A

MAINTENANCE TERMS

1. SUPPORT SERVICES

Customer will authorize and identify a reasonable number of contacts who may initiate support with equivant. These named users must be technically capable and familiar with the products covered under this Agreement. Customer will perform basic troubleshooting before contacting equivant to eliminate issues caused by other variables such as applications, power, hardware, security, infrastructure, and environment. equivant reserves the right to decline support to Customer named users not authorized to initiate support.

equivant will provide support after confirming Customer has been unable to resolve the issue through its own troubleshooting. Once the reported problem can be reproduced and documented, and resolution identified such as assistance provided over the phone, application working as documented, configuration change, or programming change, the ticket will be closed. If a programming change is required, the ticket will remain open until the updated fix is delivered in a future release.

Maintenance includes bug fixes and telephone support and may include, if they are made available by equivant, software updates.

2. CORRECTION OF DEFECTS

In the event the Customer encounters an error and/or malfunction (“Defect”) in the equivant Software because it is not conforming to documentation provided by equivant, it shall communicate the circumstances and any supporting information to equivant. Upon receipt, equivant will respond as follows:

a. In the event that, in the mutual and reasonable opinion of equivant and the Customer, there exists a Defect that does not constitute a serious impediment to the normal intended use of the equivant Software, equivant will correct the Defect and distribute the correction to the Customer in accordance with equivant’s normal software revision schedule.

b. In the event that, in the mutual and reasonable opinion of equivant and the Customer, there exists a Defect that does constitute a serious impediment to the normal intended use of the equivant Software, equivant will take such steps as are reasonably required to correct the Defect promptly.

3. SOFTWARE REVISIONS AND NEW VERSIONS

a. equivant Software may be revised by equivant as a result of (i) emergency correction of Defect, (ii) periodic correction of Defects and/or (iii) the release of upgrades or improvements or modifications designed to improve the performance of the equivant Software and/or to increase the capabilities of the equivant Software (hereafter "Revisions").

b. Revisions will be provided at no additional charge during the term of the Software Maintenance Agreement.

c. New Versions (“New Versions”) of the equivant Software may be issued by equivant from time to time (excluding 3rd party software). A New Version substantially changes the architecture and/or coding structure of the application, and the New Version is not written as an add-on to the current software code base. equivant will, from time to time, release new products (including New Versions) and/or modules, which equivant will make available to Customer at the then-current price(s).

d. All Revisions and New Versions will be transmitted to the Customer electronically unless otherwise mutually agreed. The Customer shall be solely responsible for executing the appropriate instructions in order to transfer the Revisions or New Versions onto to its system unless otherwise mutually agreed in writing.

e. If Customer reports a Defect to equivant that can be resolved through upgrading to a New Revision, Customer must upgrade to the New Revision and equivant is not obligated to correct the Defect through remediation of the older version unless otherwise mutually agreed in writing.

f. equivant Software is designed as standard products and not as customized systems. equivant recognizes the need for some Customer customization; however, equivant reserves the right to control the design, performance, and integration of equivant products and, as a result, may reject Customer requests for modifications or enhancements that are inconsistent with equivant’s product strategy.

g. equivant will use commercially reasonable efforts to modify the equivant Software in order to maintain its existing functionality and provide functionality required as a result of changes to the law, regulations, or rules of the Customer’s State jurisdiction. A change to the law, regulations, or

rules of the Customer's State jurisdiction that requires new functionality is an enhancement. equivant, at its sole discretion, may elect to add such enhancements to the product as a Revision. If Customer requires such enhancement prior to equivant decision, if any, to add to the product, the Customer will be required to pay for such additional services at equivant's then current time and materials rate. In either case, the Customer shall timely notify equivant in writing of all requested legislative updates. The notice shall contain a summary of the modifications, identifying the applications and functions to be modified as well as detailed specification of the required changes. The Customer shall also provide a complete text, including effective date, of the legislation and/or order mandating the modifications. equivant shall then prepare a detailed functional specification for approval by Customer and the timeline required for implementation. Nothing in this provision requires equivant to undertake extraordinary efforts to complete the legislative updates or provide new functionality except as additional services as described in section 7 below. Customer agrees to cooperate with other customers in the jurisdiction to agree upon appropriate specifications.

4. TECHNICAL LITERATURE

equivant shall make available to the Customer technical literature that equivant considers relevant to the equivant Software and its use within the scope of Customer's operations.

5. REMOTE DIAGNOSTIC ACCESS

The Customer shall provide appropriate remote access capabilities by which equivant may, with the permission of the Customer, remotely access the equivant Software for the purpose of remote diagnostics and support.

6. PROPER USE

a. The Customer agrees that all reasonable effort shall be taken to ensure that neither the equivant Software nor data files are misused.

b. In the event that the Customer or its agents misuses the equivant Software or data files, including, but not limited to, inserting, updating, deleting or otherwise modifying data through a means other than the equivant Software, although equivant is not obligated to correct such misuse, equivant may attempt to correct the situation, if possible, at Customer's expense.

c. In the event that diagnostic assistance is provided by equivant, which, in the reasonable opinion of equivant, relates to problems not caused by a Defect in the equivant Software, such assistance shall be at the Customer's expense.

7. ADDITIONAL SERVICES

a. The Customer may desire to have additional modifications or minor enhancements performed; the fees for these services shall be in accordance with equivant's then current time and materials rates. Specific services may include requirements analysis, preparation of functional or programming specifications, software development, testing, documentation, installation, data conversion, training, and help desk support. equivant shall provide an estimate of cost prior to performing any of the above services. equivant shall only perform these modifications under an Amendment to this Agreement or under a separate agreement.

b. Additional support outside the scope of the support services described in this Agreement may be available to the Customer upon request. These services shall be performed on a time and materials basis.

8. RESPONSE TIMES AND AVAILABILITY

a. Definition. The Customer Support Department is the primary means of communication between the Customer and equivant regarding all equivant software issues. Customer Support provides the most efficient means to track, manage, and resolve all equivant software issues. The following table provides information on equivant's categorization of issues.

Priority	Criteria

Priority	Criteria
Urgent Extremely Severe Business Impact	Issue results in broad disruption or degradation of production environment services (not caused by the Customer's hardware or environment) causing a severe business impact to the Customer, and for which no acceptable workaround exists, including where: • A core business function is prevented from being carried out; or • An issue results in a disruption or degradation for multiple core business functions that affect one or more of the Customer's business groups.
High Serious Business Impact	An error or Software issue related to a core system or business function that causes a serious business impact to the Customer by impeding the normal intended use of the software but allowing processing to continue in a restricted manner, and for which there is no known system workaround.
Normal Moderate Business Impact	A software operational error related to a core system or business function that causes a moderate to low business impact to the Customer but does not cause a serious impediment to the normal intended use of the software, and for which a system workaround may exist; or questions about how to use the application.
Low Little or No Business Impact	System functionality is largely correct except for minor, display or cosmetic errors with non-core functions of the software that causes little or no business impact to the Customer. Includes requests for documentation changes or corrections.

b. Response Time. equivant will respond as quickly as possible to each request, but uses the response time targets for Average First Reply Time, during the defined hours of operation, provided in the table below. First Reply Time is defined as the time it takes a equivant Customer Care Agent to respond to Customer's request for assistance.

	Average First Reply Time	Average Resolution Time Target
Urgent	1 hour	As soon as possible, but no more than 24 hours
High	8 business hours	48 hours (not including development or release time)
Normal	2 business days	5 business days (not including development or release time)
Low	2 business days	Mutually agreed time or Scheduled for future release

c. Resolution Time. Resolution time will vary depending on the severity and complexity of the reported problem. Resolution time is defined as the time it takes equivant to sufficiently remedy the problem or return the system to operational status. Resolution may mean that a temporary fix has been provided to correct a problem until a permanent solution can be delivered. Average Resolution Time targets are provided in the table above. Elapsed time for development effort is not included in Resolution time.

d. Hours of Operation. equivant shall be available for support services Monday through Friday, 8 A.M. to 5 P.M. Eastern Time, except for equivant-observed holidays, which may be revised from time to time.

Vote on Motion Mrs. Lewis Aye Mr. Benton Absent Mr. Merrell Aye

8
RESOLUTION NO. 18-126

IN THE MATTER OF AMENDING THE CHILD PLACEMENT SERVICES CONTRACT BETWEEN THE DELAWARE COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, THE DELAWARE COUNTY BOARD OF COMMISSIONERS, AND PROVIDER AS LISTED:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

Whereas, Delaware County contracts with Child Care Placement providers in accordance with state and federal regulations, and

Whereas, the Director of Job & Family Services recommends approval of the following contract amendment;

Now Therefore Be It Resolved that the Delaware County Board of Commissioners approve the following contract amendment for a Child Care Placement provider:

First Amendment
To
Contract for the Provision of Child Placement
And Related Services
Between
Delaware County
and
Buckeye Ranch, Inc.

This First Amendment of the Contract For The Provision of Child Placement And Related Services is entered into this 8th day of February, 2018 by and between the Delaware County, Ohio Board of County Commissioners (hereinafter "Board"), whose address is 101 North Sandusky Street, Delaware, Ohio 43015, the Delaware County, Ohio Department of Job and Family Services, a Title IV-E Agency, (hereinafter "Agency") whose address is 140 North Sandusky Street, 2nd Floor, Delaware, Ohio 43015, and Buckeye Ranch, Inc. (hereinafter "Provider") whose address is 5665 Hoover Road, Grove City, Ohio 43123 (hereinafter collectively the "Parties.).

WHEREAS, the Parties entered into the Contract for the Provision of Child Placement and Related Services on December 21, 2017.

WHEREAS, the parties agree to the addition of certain provisions to the Contract (collectively, "Provisions").

NOW THEREFORE, the Parties agree as follows:

1. The Parties agree to amend the Agreement to add the following Provisions:

   A. The following per diem rate and service level shall be added to the rate schedule:

   Level 4 - Exceptional 2

Provider ID #	Maintenance	Admin	Other	Total
30179	$56.40	$36.00	$0.48	$92.88

2. Signatures

   Any person executing this First Amendment in a representative capacity hereby warrants that he/she has authority to sign this First Amendment or has been duly authorized by his/her principal to execute this First Amendment on such principal's behalf.

3. Conflicts

   In the event of a conflict between the terms of the Contract and this First Amendment, the terms of the First Amendment shall prevail.

4. Terms of Agreement Unchanged

   All terms and conditions of the Contract not changed by this First Amendment remain the same, unchanged, and in full force and effect.

Vote on Motion Mr. Merrell Aye Mrs. Lewis Aye Mr. Benton Absent

9
RESOLUTION NO. 18-127

IN THE MATTER OF APPROVING TRANSFER OF FUNDS FOR THE JOB AND FAMILY SERVICES DEPARTMENT:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

Transfer of Funds

FROM	**TO**
22311611-5801	22411603-4601

Workforce Investment Act/Transfers	JFS Workforce/Interfund Revenues	$15,333.61
22511607-5801 Children Services Fund/Transfers	22411604-4601 JFS Child Protection/Interfund Revenues	$225,905.49
10011110-5801 Human Services/Transfers	22411601-4601 Income Maintenance/Interfund Revenues	$466,471.00

Vote on Motion Mrs. Lewis Aye Mr. Merrell Aye Mr. Benton Absent

10
RESOLUTION NO. 18-128

IN THE MATTER OF APPROVING THE FIRST AMENDMENT TO THE MEMORANDUM OF UNDERSTANDING BETWEEN THE DELAWARE COUNTY SHERIFF 'S OFFICE AND THE DELAWARE COUNTY JOB AND FAMILY SERVICES FOR THE ASSIGNMENT OF A DEPUTY TO AID JOB AND FAMILY SERVICES:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

Whereas, The Delaware County Sheriff and the Director of Job & Family Services recommend the Memorandum Of Understanding between The Delaware County Sheriff and The Department of Job And Family Services for the Assignment of a Deputy to aid Job And Family Services;

Now, Therefore, Be It Resolved That The Board Of Commissioners Of Delaware County approve The Memorandum Of Understanding between The Delaware County Sheriff and The Department of Job And Family Services for the Assignment of a Deputy to aid Job And Family Services:

First Amendment to the MOU between Delaware County Sheriff 's Office and Delaware County Job and Family Services for the Assignment of a Deputy

The Parties mutually agree to renew the MOU providing for the assignment of a DCSO deputy to DCDJFS as approved by Resolution #15-1539, on December 28, 2015.

Amended Terms:

The Parties agree to renew this MOU until December 31, 2019, as is provided under the contract. This renewal shall be effective upon the date when the final party executes this renewal.

The Parties agree to amend the maximum reimbursement amount as follows: The parties agree that the maximum amount of reimbursement for the two-year term of this MOU shall be $74,100.00, broken out in the following manner:

- The maximum amount of reimbursement for year one of this agreement will not exceed $36,500.00.
- The maximum amount of reimbursement for year two of this agreement will not exceed $37,600.00.

All remaining provisions of the MOU shall continue in full force and effect unless specifically amended here.

Vote on Motion Mr. Benton Absent Mr. Merrell Aye Mrs. Lewis Aye

13
RESOLUTION NO. 18-129

IN THE MATTER OF APPROVING A DELAWARE COUNTY FLEXIBLE SPENDING ACCOUNT PLAN DESIGN:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

The Deputy County Administrator/Director of Administrative Services recommends approving a Delaware County Flexible Spending Account Plan Design;

Therefore Be it Resolved, the Board of Delaware County Commissioners approve a Delaware County Flexible Spending Account Plan Design:

DELAWARE COUNTY FLEXIBLE SPENDING ACCOUNT PLAN DESIGN

DELAWARE COUNTY CAFETERIA PLAN
ARTICLE I. Introductory Provisions

Delaware County, ("the Employer") hereby amends the provisions of the Delaware County Cafeteria Plan ("the Plan"), as amended, effective as of January 1, 2018. The Plan was originally effective January 1, 2017.
This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Component, to an account for reimbursement of certain Medical Care Expenses (Health FSA Account) and to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

This Plan is intended to qualify as a “cafeteria plan” under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a “self-insured medical reimbursement plan” under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 105(b). The DCAP Component is intended to qualify as a “dependent care assistance program” under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 129(a).
Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code. The Health FSA Component, if any, shall also be deemed a separate plan for purposes of applicable provisions of HIPAA and COBRA.

ARTICLE II. Definitions

“Account(s)” means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs and Section 8.5 for DCAPs.

“Benefits” means the Premium Payment Benefits, the Health FSA Benefits and the DCAP Benefits offered under the Plan.

“Benefit Package Option” means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

“Change in Status” has the meaning described in Section 4.6.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Contributions” means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits and Section 8.2 for DCAP Benefits .

“Committee” means the Benefits Committee appointed by the Board of Directors of Delaware County

“Compensation” means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, “Compensation” generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

“DCAP” means dependent care assistance program.

“DCAP Account” means the account described in Section 8.5.

“DCAP Benefits” has the meaning described in Section 8.1.

“DCAP Component” means the Component of this Plan described in Article VIII.

“Dependent” means: (a) for purposes of accident or health coverage and to the extent funded for purposes of the Health FSA Component and under the Premium Payment Component , any individual who is a tax dependent of the Participant as defined in Code § 105(b), any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) ; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 8.3(c).

The Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “Dependent.”

“Dependent Care Expenses” has the meaning described in Section 8.3.

“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 (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers’ compensation.

“Effective Date” of this Plan has the meaning described in Article 1.

“Election Form/Salary Reduction Agreement” means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium

Payment Benefits, Health FSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: exclude any leased employee; exclude any temporary employee; exclude any self-employed individual; exclude any partner in a partnership; and exclude any more-than-2% shareholder in a Subchapter S corporation The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Delaware County, and any Related Employer that adopts this Plan with the approval of Delaware County. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Article XIV and Section 15.3, "Employer" means only Delaware County.

"Employment Commencement Date" means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"General-Purpose Health FSA Option" has the meaning described in Section 7.3(b).

"Health FSA" means health flexible spending arrangement, which consists of four options (if applicable): the General-Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; the Employee- Only Health FSA Option; and the Employee-Plus-Children Health FSA Option.

"Health FSA Account" means the account described in Section 7.5.

"Health FSA Benefits" has the meaning described in Section 7.1.

"Health FSA Component" means the Component of this Plan described in Article VII.

"High Deductible Health Plan" means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the employer. The High Deductible Health Plan may or may not be the sole Medical Insurance Plan eligible for pre-tax Salary Reduction funding hereunder.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO" means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45. The Employer does not currently offer an HRA.

"Limited (Vision/Dental/Preventive Care) Health FSA Option", if offered by the employer, has the meaning described in Section 7.3(b).

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (with PPO options). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"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 Spouse and Dependents, if applicable, under one or more of the Reimbursement Account benefits offered under the Plan. The amount of Employer contribution that is applied towards the cost of the Reimbursement Account benefits(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward 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 SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Reimbursement Accounts offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

"Open Enrollment Period" with respect to a Plan Year means the month preceding the Plan Year, or such other period as may be prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Insurance Benefits, Health FSA Benefits, DCAP Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan (if any) with after-tax dollars outside of

this Plan and who have not elected any Health FSA Benefits or DCAP Benefits.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"Plan" means the Delaware County Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Administrator" means Delaware County. The contact person is the Human Resources Manager or the equivalent thereof for Delaware County, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

"Plan Year" means the 12-month period commencing January 1 and ending on December 31.

"PPO" means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

"Premium Payment Benefits" means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

"Premium Payment Component" means the Component of this Plan described in Article VI.

"Qualified Reservist Distribution" means a distribution of all or a portion of the balance in the employee's account under such arrangement if: (A) such individual is a member of a "reserve component" (as defined in section 101 of title 37, United States Code, which means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service); (B) has been ordered or called to active duty for a period in excess of 179 days or for an indefinite period; (C) the amount of the distribution must be for "all or a portion of the balance in the employee's account"; and (D) the distribution must be made within a certain timeframe. The period for making a qualified reservist distribution begins on the date the reservist is called or ordered to duty and ends on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualifying Individual" has the meaning described in Section 8.3.

"Related Employer" means any employer affiliated with Delaware County that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with Delaware County for purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the foregoing, for purposes of the DCAP Component the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; (b) is working 30 or more hours per week; and (c) has been employed by the Employer for 1 consecutive calendar month(s), counting his or her Employment Commencement Date as the first such day. Eligibility for Premium Payment Benefits may also be subject to the additional requirements, if any, specified in the Medical Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the month coinciding with or following the date the eligibility requirements have been met, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

• the termination of this Plan; or

• the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination.

3.4 FMLA Leaves of Absence

Under FMLA, the provisions of this section shall not be available to Eligible Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Eligible Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

(a) *Health Benefits*. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. The Participant shall also be eligible to participate in an Employer's open enrollment, if any, while on leave.

An Employer may require participants to continue all Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (for instance, on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

• with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

• with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

• under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Insurance Benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.
If a Participant's Insurance Benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Insurance Benefits or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Insurance Benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant 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 Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules detailed in Article IV will apply.

Notwithstanding any provision to the contrary in this Plan, the Participant shall also be eligible to participate in an employer's open enrollment, if any, while on leave.

ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described in Article IV.

For the Premium Only Plan only, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described in Article IV), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding: participation in this Plan;

• Salary Reduction amounts; or

• election of particular Benefit Package Options(including the various Health FSA Options).

4.5 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, 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 next calendar month 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 that the coverage in the applicable Benefit Package Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components see Section 7.4 and Section 8.4 respectively.

4.6 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other

events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

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

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

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

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.7 Other Events Permitting Exception to Irrevocability Rule for Other Benefits (Except as Otherwise Indicated)
A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) *Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election during the Open Enrollment Period.

(b) *Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c*) Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) *Change in Status (Applies to Premium Payment, Health FSA as Limited Below, and DCAP Benefits as Limited Below)* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for: (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

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

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if: (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §

129.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

• a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

• a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 4.7(e), the term “loss of eligibility” includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an “Order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant’s child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant’s Spouse or former Spouse) provide coverage under that individual’s plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment and Health FSA Benefits as limited below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant’s Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant’s Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 4.7(h), “similar coverage” means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse’s or Dependent’s employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees’ elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant’s Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 4.7 (h)(1) through 4.7(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 4.7(h) applies also to this Section 4.7(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

• a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

• a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

• any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make

an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

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

(6) *Revocation of Medical Coverage Due to Reduction in Hours.* A participant may revoke his or her major medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another medical plan no later than the first day of the second full month following the revocation.

(7) *Revocation of Medical Coverage for Purposes of Enrolling in Marketplace Coverage.* A participant may revoke his or her major medical coverage if he or she is seeking to enroll, along with that of any related individuals who cease coverage due to such revocation, in Marketplace coverage (either during the Marketplace's annual open enrollment period or during a special enrollment period) immediately after the revoked coverage ends.
A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

4.8 RESERVED

4.9 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

Premium Payment Benefits, as described in Article VI;
(a) Health FSA Benefits, as described in Article VII. The Health FSA election may be for:

• General-Purpose Health FSA Option;

• Limited (Vision/Dental/Preventive Care) Health FSA Option

(b) DCAP Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* For Participants who elect Insurance Benefits described in Article VI, the Employer will contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. The Employer may, but is not required to allocate Nonelective Contributions to one or more Reimbursement Accounts and to the extent set forth in the SPD or enrollment material, may allow a Participant to allocate his allotted share of Nonelective Contributions among the various Reimbursement Accounts in a manner set forth in the SPD or enrollment material.

(b) *Participant Contributions.* Participants who elect any of the Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits,

Section 7.2 for Health FSA Benefits, and Section 8.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component or DCAP Component to the extent permitted under Section 4.7, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 4.7, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits, and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) *After-Tax Contributions for Premium Payment Benefits.* For those Participants who elect to pay their share of the Contributions for any of the Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits and Section 8.4(b) for DCAP Benefits

ARTICLE VI. Premium Payment Component

6.1 Benefits

The only Insurance Benefits that are offered under the Premium Payment Component are benefits under the Health, Vision and Dental Plan. The Medical Insurance Benefits are for major medical insurance (with PPO options). Notwithstanding any other provision in this Plan, the Medical Insurance Benefits are subject to the terms and conditions of the Medical Insurance Plan, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Insurance Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and to pay for his or her share of the Contributions, if any, for Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article IV), such election is irrevocable for the duration of the Period of Coverage to which it relates.

At its discretion, the Employer may offer cash in lieu of benefits.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan

Medical Insurance Benefits will be provided by the Medical Insurance Plan, not this Plan. The types and amounts of Medical Insurance Benefits (here, major medical insurance), the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plan are set forth in the Medical Insurance Plan. All claims to receive benefits under the Medical Insurance Plan shall be subject to and governed by the terms and conditions of the Medical Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA.

Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in

one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant and any Nonelective Contributions allocated thereto by the Employer, subject to the dollar limits set forth in Section 7.4(b). (For example, if the maximum $2,650.00 annual benefit amount is elected, then the annual Contribution amount is also $2,650.00.)

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.
(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is fumished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected.

• General-Purpose Health FSA Option. For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

Orthodontia Expenses. Orthodontia expenses will be reimbursed "as paid only". See below example.

Example: As paid only (i.e., in advance of services rendered, regardless of amount)
Rachel participates in a calendar-year health FSA in 2015, 2016, and 2017. In October 2015, she signs an agreement with an orthodontist to work on her son Ethan's teeth. During the first visit (November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges $5,000. Rachel is required to pay a $2000 down payment and $200 for each month thereafter. She decides to pay the entire $5000 during the first visit to avoid any interest being charged. The entire $5000 will be reimbursable from her 2015 Health FSA.

PLEASE NOTE: "Down" payments for orthodontia are immediately reimbursable.
HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA Account balance 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 such claims have been submitted).

7.4 Maximum and Minimum Benefits for Health FSA

(a*) Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 . Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective , provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $2,650.00, subject to the terms of Section 7.5(c). The minimum annual benefit amount that a Participant may elect to receive under this

Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $0.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

Changes Made by Employer and/or Mandated by the Patient Protection and Affordable Care Act (PPACA). For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. Furthermore, in accordance with PPACA mandates, effective January 1, 2013, and notwithstanding anything else in this document to the contrary, at no time shall any Participant be able to salary-reduce more than $2,500 for the 2013 or 2014 calendar year with regard to the Health FSA. Beginning January 1, 2016, at no time shall any Participant be able to salary-reduce more than $2,600 for any calendar, subject only to any increases to such limit declared by the Internal Revenue Service in future years. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article IV (other than under Section 4.7(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 4.7(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Expenses for OTC Drugs and Medicines Not Reimbursable after December 31, 2010 without a Doctor's Prescription.* Notwithstanding anything else in this document to the contrary, no expense for an over-the-counter drug or medicine incurred on or after January 1, 2011 shall be reimbursable by the Health FSA Account unless a valid prescription for same (as determined under applicable state law) is provided.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period .

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time . Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Unused Funds

(a) *Rollover of Unused Funds.*

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage (including any reimbursements made during a run-out period), then any such balance up to $500 shall be carried over to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year, provided that the Participant has not exercised his or her right to waive any right to any such carryover and provided that the Employer does not require an election for the subsequent Plan Year. Notwithstanding the foregoing, the Participant shall forfeit all rights with respect to any such balance above $500.

(b) Use *of Forfeitures.*

All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health

FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 3 month(s) after the date that eligibility ceases, as described in Section 7.8) setting forth:

• the person(s) on whose behalf Medical Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant ceases to be a Participant.
Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5(a) and Section 7.5(b) without regard to Section 7.5(c), they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 Qualified Reservist Distribution

Under the Health FSA Component, a Participant may receive a distribution of all or a portion of the balance in the employee's account if the distribution qualifies as a "Qualified Reservist Distribution".

"Qualified Reservist Distribution". In order for a distribution to be a "qualified reservist distribution", a number of requirements must be satisfied. First, a "qualified reservist distribution" can be made only to a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service. Second, the distributions can be made only to a reservist that, by reason of being a member of a "reserve component", has been ordered or called into active duty (i) in excess of 179 days or more or (ii) for an indefinite period. Third, the amount of the distribution must be for "all or a portion of the balance in the employee's account". Fourth, the distribution must be made within a certain timeframe. The period for making a qualified reservist distribution must be made on or before the last day of the coverage period that includes the date of the reservist's call to active duty and ends on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

A Qualified Reservist will be allowed to cash out the unused benefits and not forfeit them under the "use it or lose it" rule that applies to health FSAs. Specifically, the HEART Act allows for a taxable, penalty-free "qualified reservist distributions" from a health FSA without subjecting other amounts in the cafeteria plan or health FSA to immediate taxation.

7.10 Coordination of Benefits With HSA, HRA, etc.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

7.11 Coordination of Benefits With HSA, HRA, etc.

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A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank, unless the HSA contribution is limited to self-only coverage . Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

ARTICLE VIII. DCAP Component

8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000.00 annual benefit amount is elected, then the annual Contribution amount is also $5,000.00.)

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.*

A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) Dependent Care Expenses.

"Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Individual.*

"Qualifying Individual" means:

• a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);

• a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

• a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

(d) *Qualifying Dependent Care Services.*

"Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

• in the Participant's home; or

• outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) *Exclusion.*

Dependent Care Expenses do not include amounts paid to:

• an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;

• a Participant's Spouse;

• a Participant's child (as defined in Code § 152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or

• a parent of a Participant's under age 13 qualifying child (as defined in Code § 152(a)(1)).

8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.*

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) Maximum and Minimum Dollar Limits.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00. The maximum annual benefit amount that a

Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000.00 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

• the Participant's Earned Income for the calendar year;

• the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

• either $5,000.00 or $2,500 for the calendar year, as applicable:

(1) $5,000.00 for the calendar year if one of the following applies:

- the Participant is married and files a joint federal income tax return;

- the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or

- the Participant is single or is the head of the household for federal income tax purposes; or

(2) $2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00.

Changes; No Proration.

For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(c) Effect on Maximum Benefits If Election Change Permitted.

Any change in an election under Article IV affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

8.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts.*

A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.*

A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount.*

As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year.

The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Claims Procedure for DCAP

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 3 month(s) after the date that eligibility ceases, as described in Section 9.8), setting forth:

• the person(s) on whose behalf Dependent Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

• the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

(c) *Claims Denied.*

For reimbursement claims that are denied, see the appeals procedure in Article XIII.

8.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

8.9 Report to DCAP Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

ARTICLE IX. RESERVED
ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article X:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

• not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

• ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

• not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

• report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

• make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

• make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

• make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

• make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;

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

information infeasible; and

• ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

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

10.6 Adequate Separation Between Plan and Employer

The Employer shall allow the following persons access to PHI: the Vice President of Human Resources; the Benefits Manager; assistants to the Vice President of Human Resources and the Benefits Manager; Human Resources and payroll staff performing Health FSA functions; the Benefits Committee; the Plan Administrator; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

ARTICLES XI and XII. RESERVED
ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Medical Insurance Benefits

Claims and reimbursement for Medical Insurance Benefits shall be administered in accordance with the claims procedures for the Medical Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Medical Insurance Plan.

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and 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 discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by

which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 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. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 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.

14.6 Compensation of Plan Administrator

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

14.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) 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 be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.8 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 Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Ohio, to the extent not superseded by the Codeor any other federal law.

15.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code , the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Vote on Motion Mr. Benton Absent Mr. Merrell Aye Mrs. Lewis Aye

14
RESOLUTION NO. 18-130

IN THE MATTER OF APPROVING AN AUTHORITY TO REPRESENT AND AUTHORIZING THE FILING OF A CIVIL COMPLAINT AGAINST MANUFACTURERS AND DISTRIBUTORS OF PRESCRIPTION OPIATES:

It was moved by Mrs. Lewis, seconded by Mr. Merrell that the following resolution be adopted:

WHEREAS, there exists a serious public health and safety crisis in this County involving opioid abuse, addiction, morbidity, and mortality, and is a public nuisance; and

WHEREAS, the Board of County Commissioners has the authority to take action to protect the public welfare of the citizens of this County; and

WHEREAS, the Board of County Commissioners have duly considered the litigation filed by other Ohio counties against the manufacturers and wholesale distributors of prescription opiates; and

WHEREAS, the Board of County Commissioners believes it is in the best interest of the citizens of this County to pursue similar litigation; and

WHEREAS, Paul T. Farrell, Jr., a West Virginia attorney licensed to practice law in Ohio, has designed a plan and assembled a national consortium of elite trial counsel that includes TAFT STETTINIUS & HOLLISTER LLP to investigate, pursue civil litigation against those in the chain of manufacturing and distribution of prescription opiates responsible for the public health and safety crisis; and

WHEREAS, the Delaware County Court of Common Pleas has granted the joint application of the Board of County Commissioners and the Prosecuting Attorney to retain TAFT STETTINIUS & HOLLISTER LLP as special counsel for this purpose; and

WHEREAS, the Board of County Commissioners has conferred with special counsel regarding the potential civil liability of those in the chain of manufacturing and distribution of prescription opioids which caused or contributed to the opioid epidemic plaguing our community; and

WHEREAS, the Board of County Commissioners has considered the terms of the Authority to Represent necessary to retain special counsel; and

WHEREAS, the retention of special counsel is necessary and desirable given the expertise required to prosecute this complex case against the manufacturers and wholesale distributors. The citizens of this County will benefit from the retention of special counsel on a contingent fee basis. There is no fee if there is no recovery. There is no reimbursement of litigation expenses if there is no recovery. Such counsel shall not exercise any administrative discretion in the formulation of public policy, expenditure of public funds, enforcement of laws, rules and regulations of the state or any political subdivision, or execution of public trusts. The Board of County Commissioners shall retain the authority to decide the disposition of the case and maintain absolute control of the litigation.

NOW, THEREFORE, BE IT RESOLVED, the Board of County Commissioners hereby approves, and authorizes the President of the Board to execute, the Authority to Represent in substantially the form set forth herein for the retention of TAFT STETTINIUS & HOLLISTER LLP as special counsel to assist the Board of County Commissioners in the pursuit of civil litigation to abate or cause to be abated the public nuisance of opioid abuse, addiction, morbidity and mortality caused by the manufacturers and wholesale distributors of prescription opiates on a contingent fee basis.

BE IT FURTHER RESOLVED, that the Board of County Commissioners hereby authorizes the filing of a civil action and directs special counsel to perform all due diligence and take appropriate action against all manufacturers and wholesale distributors legally responsible for causing or contributing to the opioid epidemic plaguing our community.

AUTHORITY TO REPRESENT

RE: Delaware County (Ohio) civil suit against those legally responsible for the wrongful distribution of prescription opiates and damages caused thereby.

The DELAWARE COUNTY BOARD OF COMMISSIONERS (hereinafter "CLIENT") hereby retains the law firm TAFT STETTINIUS & HOLLISTER LLP, pursuant to the Ohio Rules of Professional Responsibility and O.R.C. § 305.14, on a contingent fee basis, to pursue ***all*** civil remedies against those in the chain of manufacturing and distribution of prescription opiates responsible for the opioid epidemic which is plaguing Delaware County (Ohio) including, but not limited to, filing a claim for public nuisance to abate the damages caused thereby. **David J. Butler, Esq.** (Ohio #0068455) of the law firm TAFT STETTINIUS & HOLLISTER LLP shall serve as LEAD COUNSEL. CLIENT authorizes lead counsel to employ and/or associate additional counsel, with consent of CLIENT, to assist LEAD COUNSEL in the just prosecution of the case. CLIENT consents to the participation of the following firms:

TAFT STETTINIUS & HOLLISTER LLP
65 E. State St.
Suite 1000
Columbus, OH 43065

GREENE, KETCHUM, FARRELL, BAILEY & TWEEL, LLP
419 11th Street
Huntington, West Virginia

LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA
316 South Baylen Street
Pensacola, Florida

BARON & BUDD, PC
3102 Oak Lawn Avenue #1100
Dallas, Texas

HILL PETERSON CARPER BEE & DEITZLER PLLC
500 Tracy Way
Charleston, West Virginia

MCHUGH FULLER LAW GROUP
97 Elias Whiddon Rd
Hattiesburg, Mississippi

POWELL & MAJESTRO, PLLC
405 Capitol Street, Suite P-1200
Charleston, WV 25301

In consideration, CLIENT agrees to pay thirty percent (30%) of the total recovery (gross) in favor of the CLIENT as an attorney fee whether the claim is resolved by compromise, settlement, or trial and verdict (and appeal). The gross recovery shall be calculated on the amount obtained before the deduction of costs and expenses. CLIENT grants Attorneys an interest in a fee based on the gross recovery. If a court awards attorneys' fees, Attorneys shall receive the "greater of" the gross recovery-based contingent fee or the attorneys' fees awarded. **There is no fee if there is no recovery.**

TAFT STETTINIUS & HOLLISTER LLP and the other law firms, hereinafter referred to as the "Attorneys," agree to advance all necessary litigation expenses necessary to prosecute these claims. All such litigation expenses, including the reasonable internal costs of electronically stored information (ESI) and electronic discovery generally or the direct costs incurred from any outside contractor for those services, will be deducted from any recovery after the contingent fee is calculated. **There is no reimbursement of litigation expenses if there is no recovery.**

The CLIENT acknowledges this fee is reasonable given the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly, the likelihood this employment will preclude other employment by the Attorneys, the fee customarily charged in the locality for similar legal services, the anticipated (contingent) litigation expenses and the anticipated results obtained, the experience, reputation, and ability of the lawyer or lawyers performing the services and the fact that the fee is contingent upon a successful recovery.

This litigation is intended to address a significant problem in the community. The litigation focuses on the manufacturers and wholesale distributors and their role in the diversion of millions of prescription opiates into the illicit market which has resulted in opioid addiction, abuse, morbidity and mortality. There is no easy solution. Many of the facts of the case are locked behind closed doors. The billion dollar industry denies liability. The litigation will be very expensive and the litigation expenses will be advanced by the Attorneys with reimbursement contingent upon a successful recovery. The outcome is uncertain, as is all civil litigation, with compensation contingent upon a successful recovery. Consequently, there must be a clear understanding between the CLIENT and the Attorneys regarding the definition of a "successful recovery."

The Attorneys intend to present a damage model designed to abate the public health and safety crisis. This damage model may take the form of money damages or equitable remedies (e.g., abatement fund). The purpose of the lawsuit is to seek reimbursement of the costs incurred in the past fighting the opioid epidemic and/or recover the funds necessary to abate the health and safety crisis caused by the unlawful conduct of the manufacturers and wholesale distributors. The CLIENT agrees to compensate the Attorneys, contingent upon prevailing, by paying 30% of any settlement/resolution/judgment, in favor of the CLIENT, whether it takes the form of monetary damages or equitable relief. For instance, if the remedy is in the form of monetary damages, CLIENT agrees to pay 30% of the gross amount to Attorneys as compensation and then reimburse the reasonable litigation expenses. If the remedy is in the form of equitable relief (e.g., abatement fund), CLIENT agrees to pay 30% of the gross value of the equitable relief to the Attorneys as compensation and then reimburse the reasonable litigation expenses. To be clear, Attorneys shall not be paid nor receive reimbursement from public funds. However, any judgment arising from successful prosecution of the case, or any consideration arising from a settlement of the matter, whether monetary or equitable, shall not be considered public funds for purposes of calculating the contingent fee. Under no circumstances shall the CLIENT be obligated to pay any Attorneys fee or any litigation expenses except from moneys expended by defendant(s) pursuant to the resolution of the CLIENT's claims. If the defendant(s) expend their own resources to abate the public health and safety crisis in exchange for a release of liability, then the Attorneys will be paid the designated contingent fee from the resources expended by the defendant(s). CLIENT acknowledges this is a necessary condition required by the Attorneys to dedicate their time and invest their resources on a contingent basis to this enormous project. If the defendant(s) negotiate a release of liability, then the Attorneys should be compensated based upon the consideration offered to induce the dismissal of the lawsuit.

The division of fees, expenses and labor between the Attorneys will be decided by private agreement between the law firms and subject to approval by the CLIENT. Any division of fees will be governed by the Ohio Rules of Professional Conduct including: (1) the division of fees is in proportion to the services performed by each lawyer or each lawyer assumes joint responsibility for the representation and agrees to be available for consultation with the CLIENT; (2) the CLIENT has given *written* consent after full disclosure of the identity of each lawyer, that the fees will be divided, and that the division of fees will be in proportion to the services to be performed by each lawyer or that each lawyer will assume joint responsibility for the representation; (3) except where court approval of the fee division is obtained, the *written* closing statement in a case involving a contingent fee shall be signed by the CLIENT and each
lawyer and shall comply with the terms of Rule 1.5 (c)(2) of the Ohio Rules of Professional Conduct; and (4) the total fee is *reasonable*.

LEAD COUNSEL shall appoint a contact person to keep the CLIENT reasonably informed about the status of the matter in a manner deemed appropriate by the CLIENT. The CLIENT at all times shall retain the authority to decide the disposition of the case and personally oversee and maintain absolute control of the litigation.

Upon conclusion of this matter, LEAD COUNSEL shall provide the CLIENT with a written statement stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of its determination. The closing statement shall specify the manner in which the compensation was determined under the agreement, any costs and expenses deducted by the lawyer from the judgment or settlement involved, and, if applicable, the actual division of the lawyers' fees with a lawyer not in the same firm, as required in Rule 1.5 (e)(3) of the Ohio Rules of Professional Conduct. The closing statement shall be signed by the CLIENT and each attorney among whom the fee is being divided.

Nothing in this Agreement and nothing in the Attorneys' statement to the CLIENT may be construed as a promise or guarantee about the outcome of this matter. The Attorneys make no such promises or guarantees. Attorneys' comments about the outcome of this matter are expressions of opinion only and the Attorneys make no guarantee as to the outcome of any litigation, settlement or trial proceedings.

SIGNED, this ______ day of _______________, 2018.

DELAWARE COUNTY BOARD OF COMMISSIONERS

____
Gary Merrell, President
Pursuant to Resolution No. 18-_______________

Accepted:

TAFT STETTINIUS & HOLLISTER LLP
65 E. State Street, Suite 1000
Columbus, Ohio 43065

By _____________________________ _____________
David J. Butler, Esq. Date
Lead Counsel

CLERK OF COURTS
DELAWARE COUNTY, OHIO
COMMON PLEAS COURT
FILED
2018 FEB -2 AM 8:17

IN THE COURT OF COMMON PLEAS
OF DELAWARE COUNTY, OHIO

IN RE APPOINTMENT OF LEGAL COUNSEL FOR DELAWARE COUNTY BOARD OF COMMISSIONERS	:	**Case No.**

JUDGMENT ENTRY APPOINTING LEGAL COUNSEL FOR DELAWARE COUNTY BOARD OF COMMISSIONERS

Upon joint application of Carol Hamilton O'Brien, Prosecuting Attorney, Delaware County, Ohio ("Prosecutor"), and the Board of Commissioners, Delaware County, Ohio ("Board"), pursuant to R.C. 305.14(A) and the inherent powers of the Court, this Court does hereby find that it is appropriate to appoint legal counsel to advise, represent, prosecute on behalf of, and/or defend the Board in and as related to the multi-district litigation currently pending against manufacturers and distributors of opioid medications and in any related matters that may arise.

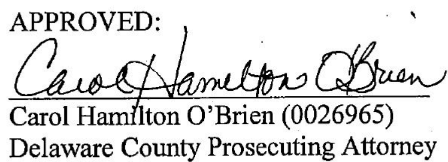
Therefore, it is the **ORDER** of this Court that the firm of Taft Stettinius & Hollister LLP is hereby appointed as legal counsel for the Board in this matter and in any related matters. Compensation shall be on a contingency basis as set forth in an agreement between the firm and the Board.

IT IS SO ORDERED.

JUDGE

Dated: 2-1-18

APPROVED:


Carol Hamilton O'Brien (0026965)
Delaware County Prosecuting Attorney

cc: Prosecutor's Office
Board of Commissioners

Vote on Motion	Mr. Merrell	Aye	Mrs. Lewis	Aye	Mr. Benton	Aye

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ADMINISTRATOR REPORTS
Dawn Huston, Deputy County Administrator
-No reports

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COMMISSIONERS' COMMITTEES REPORTS
Commissioner Lewis
-Presented at the Genoa Business Association breakfast yesterday with Commissioner Merrell and Administrator, Mike Frommer.

Commissioner Merrell
-Met with Bob Horrocks yesterday concerning the Veteran's Day Breakfast. Working on a solution that will benefit the local veterans.
-Will be speaking at the Delaware Leadership meeting today.

17
RESOLUTION NO. 18-131

IN THE MATTER OF ADJOURNING INTO EXECUTIVE SESSION FOR CONSIDERATION OF EMPLOYMENT OF A PUBLIC EMPLOYEE OR PUBLIC OFFICIAL:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to approve the following:

WHEREAS, pursuant to section 121.22(G) of the Revised Code, a public body may hold an executive session only after a majority of a quorum of the public body determines, by a roll call vote, to hold an executive session and only at a regular or special meeting for the sole purpose of the consideration of any of the matters specified in section 121.22(G)(1)–(7) of the Revised Code; and

NOW, THEREFORE, BE IT RESOLVED by the Board of Commissioners of Delaware County, State of Ohio:

Section 1. The Board hereby adjourns into executive session for consideration of employment of a public employee or public official.

Vote on Motion Mrs. Lewis Aye Mr. Merrell Aye Mr. Benton Absent

RESOLUTION NO. 18-132

IN THE MATTER OF ADJOURNING OUT OF EXECUTIVE SESSION:

It was moved by Mrs. Lewis, seconded by Mr. Merrell to adjourn out of Executive Session.

Vote on Motion Mr. Benton Absent Mr. Merrell Aye Mrs. Lewis Aye

There being no further business, the meeting adjourned.

____
Gary Merrell

____
Barb Lewis

____
Jeff Benton

____
Jennifer Walraven, Clerk to the Commissioners