VIGO COUNTY GOVERNMENT

FLEXIBLE BENEFIT PLAN

PLAN DOCUMENT

EFFECTIVE JANUARY 1, 2018

AS AMENDED AND RESTATED FROM THE ORIGINAL DOCUMENT, ALL AMENDMENTS AND PLAN RE-WRITES PRIOR TO THIS EFFECTIVE DATE

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE EMPLOYER, ANY PARTICIPATING EMPLOYER, AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

Vigo County Government Flexible Benefit Plan

Plan Document

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PURPOSE

The purpose of the Plan is to allow Employees of Vigo County Government to choose certain Benefits provided by Vigo County Government so that Employees may receive Benefits that best meet their individual needs. Vigo County Government intends that the Plan qualify as a cafeteria plan within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended, and that the Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes. Vigo County Government may offer a choice among additional Benefits that may not constitute Benefits, but nothing in this Plan shall be construed as offering any taxable Benefits except to the extent that Vigo County Government may otherwise specifically provide.

SECTION I
Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"Affiliated Employer" means:

A. any corporation which is a member of a controlled group of corporations including those within the meaning of Section 1563(a) and 414(b) of the Code, determined without regard to Sections 1563(a)(4) and (e)(3)(C), including the Employer;
B. any organization under common control with the Employer within the meaning of Section 414(c) of the Code;
C. any organization which is included with the Employer in an Affiliated service group within the meaning of Section 414(m) of the Code; or
D. any other entity required to be aggregated with the Employer pursuant to regulations under Section 414(o) of the Code.

"Benefit Credits" means the amount set aside for Benefits under Section III and credited to the Participant's Reimbursement Account(s).

"Benefits" means the Benefits of Vigo County Government Flexible Benefit Plan as described herein, and as set forth in the Schedule of Benefits attached hereto. Each Benefit is described in Section 125(f) of the Code and the regulations promulgated thereunder.

"Board" means the Board of Directors of Vigo County Government.

"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, his Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of work or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility condition of this Plan or other employee benefits plan of the Participant, his 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, 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, or any similar circumstance; and

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

(f) Any other events included under Code Section 125 regulations or other guidance promulgated thereunder relating to changes in family status. The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code Section 125.

"Close Relative" means a member of the Participant's family, including spouse, brother, sister, child or parent.

"Code" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

"Committee" means the individual who may be appointed by the Plan Administrator to administer the process of claims review for the Plan in accordance with Section V.

"Compensation" means the total wages including salary, overtime and any bonus paid by a Participating Employer for services rendered during the Plan Year.

"Compensation Reduction Agreement" means a voluntary Agreement whereby an Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if the Agreement becomes effective after the beginning of the Plan Year, for the balance of that Plan Year), for purposes of obtaining the Benefits offered by the Plan.

"Debit Card" means Vigo County Government permits electronic reimbursement of medical Expenses through the use of a Debit Card. Each participating Employee is issued a Debit Card and certifies upon enrollment in the health FSA and each Plan Year thereafter that the Debit Card will only be used for eligible medical care Expenses. The Employee also certifies that any Expense paid with the Debit Card has not been reimbursed and that the Employee will not seek reimbursement under any other plan covering health Benefits.

"Dependent" means that for the purposes of this Plan, any individual who is a tax Dependent of the Participant as defined in Code § 152(b), with the following exception: Any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one (1) or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents. Notwithstanding the foregoing, the Flexible Benefit Plan will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

As a result of a change to the Internal Revenue Code that was part of Federal Healthcare Reform (Patient Protection and Affordable Care Act / PPACA), a Participant in the Medical Reimbursement Account (Health FSA), can be reimbursed for Qualified Medical Services incurred by a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, student status, marital status, or status as a tax Dependent. The change applies to Expenses by a Participants natural son, natural daughter, stepchild, legally adopted child, or eligible foster child.

"Dependent Care Reimbursement Account" means the Dependent Care Reimbursement Account will reimburse qualified Child/Adult day expenses.

"Effective Date" means January 1, 2018, as amended from time to time.

"Eligible Employee" means any Employee who meets the specific eligibility requirements for the Plan. Employees who are employed by the Employer on a regular full-time basis for at least thirty (30) hours per week are eligible to participate in this Plan. Employees with more than thirty (30) days of employment are eligible for the Premium Conversion Account Plan. Employees are eligible on the first day of the Plan Year following their date of hire for the Medical and Dependent Care Reimbursement Account Plans.

"Employee" means any person who is an Employee of the Employer and regularly scheduled to work for the Employer in an Employee-Employer relationship. The term Employee does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation.

"Employer" means Vigo County Government and any other business organization which succeeds to its business and elects to continue this Plan and which adopts this Plan with the consent of the Board.

"Enrollment Period" means the period upon becoming an Eligible Employee. In addition, the Plan Administrator has specified other acceptable Enrollment Periods, which are the month prior to the Plan Anniversary and upon becoming an Eligible Employee.

"Entry Date" means the date upon which Participation begins after a Participant has enrolled in the Plan, provided written application for enrollment is submitted within 31-days from the date the person begins employment.

"Expense" means any amount paid or incurred by the Employee for an Eligible Benefit Expense not otherwise reimbursed under any group plan, the reimbursement of which by the Employer is intended to be excludable from the income of such Participant under various provisions of the Code.

"Health Benefit 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.

"Highly Compensated Employee" means any Employee defined as such in Section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1997, which may be modified or amended at any time.

"Key Employee" means any Employee defined as such in Section 416(i)(1) of the Code.

"Medical Reimbursement Account" means the Medical Reimbursement Account will reimburse qualified Section 213 Expenses.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section II.

"Participating Employer" means the Employer and any Affiliated Employer, which adopts this Plan with the consent of the Board.

"Plan" means the Vigo County Government Flexible Benefits Plan described herein and as amended from time to time.

"Plan Year" means January through December. The Plan Year will run on a twelve (12) month calendar year basis each year.

"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 and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates.

"Premium Conversion Account Plan" means the account established in each Participant's name and which is used to record the allocation of Benefit Credits for the expenditure of the Benefit program(s) elected by a Participant.

"Premium Expense" means the Premium or Expense paid for the cost of Benefits elected by the Participant.

"Prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a Prescription in the state in which the medical Expense is incurred and that is issued by an individual who is legally authorized to issue a Prescription in that state.

"QMCSO" means a qualified medical child support order.

"Qualified Medical Service" means the Medical Service must diagnose, cure, mitigate, treat or prevent disease or affect any structure or function of the body. The Medical Service must be incurred primarily for the prevention or alleviation of a physical or mental defect or illness.

"Reimbursement Accounts" means the Accounts established as provided under Section **III**, in the Participant's name and which are used to record the allocation of Benefit Credits and their expenditure for Benefits.

"Run Out Period" means the amount of time at the end of the Plan Year or termination date (whichever comes first) that a Participant has to submit claims for services incurred in the active or prior Plan Year.

"Section 213 Expenses" means a Qualified Medical Service that is considered to be medically necessary or prescribed by a licensed practitioner is eligible and the cost of which may be reimbursed or may be reimbursable by any other medical Benefit plan to the extent available, before Benefits of this Plan are available for reimbursement. The cost of such Qualified Medical Services must be supported by adequate evidence of the incurring or payment of cost, and submitted to the Employer by the Participant or his legal representative. The determination of the qualification of the Medical Service and the determination of the completeness of submitted request for reimbursement will rest solely on the Employer or person or persons appointed to review all claims. The Employer's decision in this determination will be final.

"Spouse" means the person married to a Participant. The Participant's spouse, including a spouse of the same sex, if such person is recognized as a legal spouse of the Participant in the jurisdiction in which the marriage occurred. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married; or the Participant's spouse, including a spouse of the same sex, if such person is recognized as a legal spouse in the jurisdiction in which the parties reside; or the Participant's spouse who is recognized as such for federal income tax purposes.

"Summary Plan Description (SPD)" means the document that contains a comprehensive description of the Flexible Benefit Plan, including terms and conditions of participation. The SPD provides such information as to when an Employee can begin to participate in the Plan, what Benefits are available in the Plan, when and in what form Benefits are paid, and how to file a claim for Benefits. The SPD is distributed to all Plan Participants.

SECTION II
Participation in the Plan

Commencement of Participation. Each Eligible Employee shall be eligible to become a Participant on his Entry Date. The Entry Date for the Premium Conversaion Account Plan is the first day of the month following thirty (30) days of employment. The Entry Date for the Medical and Dependent Care Reimbursement Account Plans is the first day of the Plan Year following their date of hire.

Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Compensation Reduction Agreement and by providing such data as is reasonably required by the Employer as a condition of such Participation. Section IV of this document shall govern the Compensation Reduction Agreement. By becoming a Participant, each individual shall, for all purposes, be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:

A. the date on which the Plan terminates;
B. the date on which he ceases to be an Eligible Employee;
C. the date on which he fails to make a contribution required under the terms of the Plan; or
D. the date on which a Participating Employer terminates its participation in the Plan.

Nothing in this Section shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation. Notwithstanding the foregoing, a former Participant who continues to receive Compensation from the Employer shall remain a Participant for all purposes until such Compensation ceases.

Recommencement of Participation. A reemployed former active Participant may make a new election in the Flexible Benefit Plan which is effective during the Plan Year in which he separated from service with the Employer upon satisfying the eligibility requirement set forth in such Plan.

FMLA. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (FMLA) may revoke his election to participate under any group health insurance Benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his FMLA, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his taking FMLA, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA shall have no greater rights to Benefits for the remainder of the Plan Year in which the FMLA commences as any other Plan Participant.

Change in Election. A Participant may change or revoke an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) **Open Enrollment Period.** A Participant may change or revoke an election during the Open Enrollment Period.
(b) **Termination of Employment.** A Participant's election will terminate under the Plan upon termination of employment.
(c) **Change in Status.** A Participant may change his election under the Plan upon the occurrence of a Change in Status, 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.

(1) **Loss of Spouse or Dependent Eligibility.** 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.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or his 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.

(d) **HIPAA Special Enrollment Rights.** If a Participant or his Spouse or Dependent is entitled to special enrollment rights under a group health Plan, 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.

(e) **Certain Judgments, Decrees and Orders.** 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 for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his 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.

(f) **Medicare and Medicaid.** If a Participant or his 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 coverage may be canceled. Furthermore, if a Participant or his 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.

(g) **Change in Cost/Coverage.** For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) an HMO and a PPO are considered to be similar coverage; and (2) 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 to reflect insignificant increases in their required contribution 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 elective contributions on a prospective basis.

(2) **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee significantly increases, then the Participant may (a) make a corresponding prospective increase in his elective contributions; (b) revoke his election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Health Benefit Plan that provides similar coverage; or (c) drop coverage prospectively if there is no other Health Benefit Plan 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 significantly decreases, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Plan may make a corresponding prospective decrease in their elective contributions; (b) Participants who are enrolled in another Health Benefit Plan may change their election on a prospective basis to elect the Health Benefit Plan that has decreased in cost; or (c) Employees who are otherwise eligible may elect the Health Benefit Plan that has decreased in cost on a prospective basis, subject to the terms and limitations of the Health Benefit Plan. 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.

(h) **Change in Coverage.** The definition of "similar coverage" is the same as Section (g).

(1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Health Benefit Plan 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 Health Benefit Plan (or the Participant's Spouse's or Dependent's coverage under his 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), the Participant may revoke his election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Health Benefit Plan that provides similar coverage. Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(b) **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's Health Benefit Plan coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his employer's Plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage, then the Participant may revoke his election for the affected coverage and may either prospectively elect coverage under another Health Benefit Plan that provides similar coverage or drop coverage if no other Health Benefit Plan providing similar coverage is offered by the Employer.

(c) **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage. 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 Health Benefit Plan;
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his 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 Health Benefit Plan.** If during a Period of Coverage the Plan adds a new Health Benefit Plan or significantly improves an existing Health Benefit Plan, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Health Benefit Plan other than the newly added or significantly improved Health Benefit Plan may change their elections on a prospective basis to elect the newly added or significantly improved Health Benefit Plan; and (b) Employees who are otherwise eligible may elect the newly added or significantly improved Health Benefit Plan on a prospective basis, subject to the terms and limitations of the Health Benefit Plan. 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 Health Benefit Plan in accordance with prevailing IRS guidance.

(3) **Loss of Coverage Under Other Group Health Coverage.** A Participant may prospectively change his election to add group health coverage for the Participant or his 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 Health Benefit Plan(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 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.

(i) Additional Election Changes Pursuant to IRS Notice 2014-55

Notwithstanding any other provision of the Plan to the contrary, the following additional election changes shall be permitted beginning January 1, 2015:

(a) An employee who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Health Benefit Plan coverage, provided that the employee:

(i) requests the election change within the Plan's election period and

(ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Health Benefit Plan coverage is revoked.

(b) An employee who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Health Benefit Plan coverage, provided that the employee:

(i) requests the election change within the Plan's election period and
(ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Health Benefit Plan coverage.

Election changes made pursuant to this provision will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan administrator, election changes may become effective later to the extent that the other coverage commences later), and shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change.

SECTION III
Benefits Plans, Rules and Costs

Benefit Plans

This Plan contains the Benefits of: Medical Reimbursement Account, Dependent Care Reimbursement Account Plans and Premium Conversion Account.

Medical Reimbursement Account (Health FSA)

There are some Expenses an Employee will have to pay for in the coming year; for instance, new eyeglasses, and medical and dental Expenses not reimbursed by the health Plan. Normally, an Employee would pay for Expenses like these with after-tax income. And because taxes reduce the value of a dollar, an Employee would have to earn considerably more than $100 to pay $100 of these Expenses.

If an Employee is eligible to participate, the Vigo County Government Flexible Benefit Plan allows the eligible Employee to contribute pretax income to create a special Reimbursement Account in order to reimburse themselves on a pretax basis for payment of certain Qualified Medical Services and other Qualified Section 213 Expenses (see Schedule A). The money contributed to the Reimbursement Account by automatic payroll deduction is not subject to federal or Social Security taxes, but depending on the Participant's residence, may be subject to state and local income taxes.

How the Medical Reimbursement Account Works

An Eligible Employee may establish a Reimbursement Account for predictable medical Expenses, including dental and vision care Expenses. The maximum pretax deferral allowed for the Medical Reimbursement Account during a Plan Year is shown on Schedule A. Once an Eligible Employee has completed the Compensation Reduction Agreement for the Medical Reimbursement Account, the Participant may file a claim for the aforementioned medical Expense incurred on or after their Entry Date, and during the current Plan Year, that have not been reimbursed under their Employer's Plan, another health plan, FSA plan, HSA plan, or HRA plan. Generally, the qualified Expenses are costs a Participant incurred that exceed any Plan deductibles, co-payments and co-insurance as determined as allowable medical Expenses under IRS Code Section 213, and to the limit of the elected Benefit Credits. The Plan Administrator will inform a Participant of the rules that apply to filing claims.

The Expenses covered must be medically necessary or prescribed by a licensed practitioner to qualify. Covered Expenses do not include premiums paid for other health plan coverage, including plans maintained by the employer of a family member, or Expenses for non-reconstructive cosmetic surgery, nor do they include Expenses for personal mileage.

Compensation reduction amounts in the form of Benefit Credits remaining in the Medical Reimbursement Account after all qualified claims have been filed and paid during a Plan Year cannot be carried forward in any following year, and will be forfeited.

The Medical Reimbursement Account will be debited in the amount of reimbursement, provided there are sufficient Benefit Credits available. A Participant may not add to or change their contribution amount except as a result of a Change in Status. A Participant may make a new election to change or eliminate the Compensation reduction amounts during the annual open Enrollment Period prior to the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other Reimbursement Account in this or any other Plan, or used for purposes other than for which they are originally intended.

Notwithstanding the foregoing, the maximum amount of reimbursement under the Medical Reimbursement Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treasury regulations Section 1.125-2(A-7)(b)(2).

Dependent Care Reimbursement Account

Provision of Benefits. Benefits under this Plan shall take the form of reimbursement for Dependent Care, as determined by Code Section129, by the Employer for eligible Expenses incurred by a Participant during the Plan Year. A Participant shall be entitled to Benefits under this Plan only for eligible Expenses incurred after becoming a Participant.

Amount of Reimbursement. A Participant shall be entitled to Benefits under this Plan in an amount that does not exceed his current payroll contributions to date. No Eligible Expense shall be reimbursed to the extent that the Expense exceeds such amount. Each payment hereunder shall be a charge to the Participant's Benefit Credits.

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 applicable), and Expenses for incidental household services, if paid for by the Participant to obtain Qualifying Dependent Care Services – provided, however, that this term does 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 the Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's Dependent Care Reimbursement Account imposes maximum Benefit limitations), the Employee's Dependent Care Reimbursement Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section.

"Incurred" means an eligible Expense is incurred at the of time the Qualifying Dependent Care Services giving rise to when 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).

"Qualifying Dependent Care Center" means a facility that provides full-time or part-time care for more than six (6) individuals (other than individuals who reside at the Dependent Care Center) on a regular basis during the Participant's taxable year, and which:

A. complies with all applicable laws and regulations of the state, town, city or village in which it is located; and
B. receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

"Qualifying Individual" means:

A. 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);
B. 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
C. 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 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.

"Qualifying Dependent Care Service" means Services that are:

A. related to the care of the Qualifying Individual that enable the Participant and their Spouse to remain gainfully employed after the date of participation in the Dependent Care Reimbursement Account and during the Period of Coverage; and
B. performed,
    (i) in the Participant's home; or
    (ii) 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 (8) hours per day in the Participant's household. This includes Expenses that are incurred for services provided by a Dependent Care Center.

"Exclusions" means Dependent Care Expenses which do not include amounts paid to:

A. an individual for whom a personal exemption is allowable under Code 151(c) to a Participant or his Spouse;
B. A Participant's child (as defined in Code 152(f)(1)) who is under age 19 at the end of the year in which the Expenses were incurred; or
C. A parent of a Participant's under age 13 qualifying child (as defined in Code 152(a)(1)).

Maximum Annual Benefits. A Participant who is married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of:

A. $5,000 (or $2,500 in the case of a married Participant filing a federal income tax return separate from his Spouse);
B. his Compensation for such Plan Year;
C. the Compensation of his Spouse for such Plan Year;
D. the amount set forth in Schedule B attached hereto; or
E. the Benefit Credits allocated to a Participant's account for the Plan Year.

A Participant who is not married at the close of a Plan Year may not receive reimbursement for eligible Expenses incurred by him for the Plan Year in excess of the lesser of $5,000 or his Compensation for the Plan Year. Notwithstanding the above, the maximum reimbursement paid under this Plan must also be reduced by the amount of any tax-exempt Dependent Care Reimbursement Account received by the Participant or his Spouse from any other employer during the Plan Year.

Premium Conversion Account

Benefit Credits. Upon proper election by a Participant, there shall be credited to each Participant's Premium Conversion Account any Benefit Credits that correspond to the Participant's Compensation Reduction Agreement. Such Benefit Credits shall not exceed the Premium Expense of the Benefit program elected, set forth in Schedule C attached hereto, as it may be revised by the Employer from time to time. The Participant's Benefit Credits shall be credited as and when such sum is redirected from the Participant's Compensation pursuant to the Compensation Reduction Agreement then in effect. The Benefit Credits shall be used to pay all or part of the Premium Expense of the Benefit program that the Participant has designated pursuant to Section III. The Premium Expense paid on behalf of any Participant shall be a charge to the balance of his Premium Conversion Account.

Election of Benefits. Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or at another time if a change is necessary, a written statement identifying the Benefit program to be provided by the Employer to or on behalf of the Eligible Employee. Each election under this Section may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under a Benefit program, the Employer may terminate the remaining portion of Benefit program coverage provided by the Plan. If an Eligible Employee fails to submit a written statement identifying the Benefit program to be provided by the Employer, the Employee's participation will not commence until such written statement is provided to the Plan Administrator.

Provision of Benefits. The Participating Employer shall provide the Benefit program the Participant has elected under the Plan. The Benefits provided thereunder shall be subject further to the provisions of any plan, contract, or other arrangement setting forth the further terms and conditions of the Benefit program, and the terms of each Participating Employer's plan, contract or other arrangement, under which Benefits provided are incorporated by reference in this Plan.

Revocation and Modification of Benefit Election. Except as provided in this Section, before the Plan Year has begun, a Participant may modify or revoke his designation of Benefits to the extent the Employer may provide. Any new election shall be effective at such time as the Employer shall prescribe, but not later than the first pay period beginning after the modified election form is completed and returned to the Employer.

Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not modify or revoke his election of Benefits, except on account of, and consistent with, a Change in Status.

Nondiscrimination. The Benefits of this Plan are provided to all Eligible Employees without discrimination as to eligibility or Benefits. Contributions and Benefits under the Plan shall not discriminate in favor of Highly Compensated Employees. The Employer may limit or deny any Employee's Compensation Reduction Agreement to the extent necessary to avoid any such discrimination.

Insurance Contracts. Any dividends or retroactive rates or other refunds that may become payable under any insurance, health care service contracts or Benefit programs due to actuarial error in rate calculation shall be the exclusive property of and shall be retained by a Participating Employer.

Premium Expense. The Premium Expense of each Benefit program shall be determined in a uniform manner by the Participating Employer subject to approval by the Employer. Such Premium Expenses are subject to change at the discretion of the Employer for any future Plan Year for current Participants, and at any time for new Participants.

Benefit Rules

Reimbursement Accounts. In order to allow this unique opportunity to reduce a Participant's taxable income, the IRS has placed some restrictions on Flexible Benefit Plans.

- Compensation redirection authorized for reimbursement is in effect for the entire year unless the Participant has a change in family status.
- The Participant enrolled in the Medical Reimbursement Account must use all the funds in their Reimbursement Account by the end of the Plan Year or he will forfeit them; the balances cannot be combined, carried over into the next year, or converted to cash. The Participant may continue to submit claims up to three (3) months after the Plan Year ends for the prior year's Expenses.
- The Participant enrolled in the Dependent Care Reimbursement Account must use all the funds in their Reimbursement Account by the end of the Plan Year or he will forfeit them; the balances cannot be combined, carried over into the next year, or converted to cash. The Participant may continue to submit claims up to three (3) months after the Plan Year ends for the prior year's Expenses.
- Employees who terminate employment or terminate from the Plan due to a qualifying Change in Status during the Plan Year will be given three (3) months from the date of termination in which to submit request for reimbursement for Expenses incurred before termination.

Provision of Benefits. The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount allocated to the provision of each such Benefit and subject to Employee Benefit Credits. Such Benefits shall be subject to the provisions of any plan, SPD, contract, or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided, and any condition or restriction imposed by an Employer providing any Benefit.

No amount shall be applied to provide Benefits under this Plan if such amount would exceed the balance of the Participant's Benefit Credits. However, the Employer, at its sole discretion, may defer and provide such Benefits with Employer contributions which cause the Participant's Benefit Credits to equal or exceed the amount required to provide such Benefits.

Revocation and Modification of Elections, and Change in Status. Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not amend or revoke his election of Benefits, unless there is a Change in Status or as may otherwise be permitted. The revocation of a designation of Benefits and election of new Benefits may be made by an Eligible Employee only if both the revocation of existing designation of Benefits and election of new Benefits are made on account of and consistent with the previously described Change in Status (except for coverage under COBRA or similar state coverage).

A Participant entitled to make a new election must do so within 30-days of the event. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event occurs.

Cash Payments. Any cash to be paid to a Participant with respect to any portion of the Benefit Credits (other than as Benefits) shall be added to his taxable Compensation and shall be paid to him during the Plan Year subject to any applicable wage withholding or similar taxes. Such payments shall not include interest from the date as of which the Benefit Credits were credited on the Participant's behalf to the date of payment. No Benefit under the Plan shall be paid in any manner that defers the receipt of Compensation beyond the last day of the Plan Year.

Reimbursements. Except as otherwise provided in any plan, contract or arrangement established to provide Benefits, reimbursement of Expenses shall be made at such time and in such amounts as shall be determined by the Employer in accordance with Treasury Regulations 1.125-2 Q&A 7(b)(2). The amount credited to the Participant's Reimbursement Account(s) for any Plan Year shall be used only to reimburse the Participant for Qualified Benefit up to three (3) months following the end of the Plan Year.

Nondiscrimination. Contributions and Benefits under the Plan shall not discriminate in favor of Highly Compensated Employees nor shall the aggregate cost of the Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Benefits provided to all Employees under the Plan. The Employer may limit or deny any Employee's Compensation Reduction Agreement to the extent necessary to avoid any such discrimination.

Insurance Contracts. Some or all of the Benefits provided under the Plan may, at the discretion of the Employer, be provided by the purchase of insurance contracts issued by one or more insurance companies, or health care service contracts issued by or provided through a health care service provider, qualified health maintenance organization, or preferred provider organization. Any dividends, retroactive rates, or other refunds which may become payable under any insurance or health care service contracts or Benefit programs due to actuarial error in rate calculation shall be the property of and retained by the appropriate Participating Employer.

Forfeiture of FSA Accounts; Use-It-or-Lose-It Rule.

(a) Use-It-or-Lose-It Rule. If any balance remains in the Participant's Medical or Dependent Care Reimbursement 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 qualified Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balances.

(b) Use of Forfeitures. All forfeitures under this Plan shall be used as follows:

(1) to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Benefit Credits;

(2) to reduce the cost of administering the Flexible Benefit Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and

(3) 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 Reimbursement 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 Expense was incurred shall be forfeited and applied as described above.

Benefit Costs

The cost of each Benefit shall be determined in a uniform manner according to the Benefit option cost described in Schedule A, B and C attached hereto. Such costs are subject to change, at the discretion of the Employer, for any future Plan Year for current Participants and at any time prior to the commencement of participation for new Participants.

Termination of Employment. If an Eligible Employee separates from service with the Employer during a period in which he is covered under the Plan, the Employer may terminate the remaining portion of Benefits provided by the Plan. A terminated Employee shall be entitled to reimbursement for claims for Benefits incurred prior to his termination of employment, only if the Employee (or his estate) applies for such reimbursement up to three (3) months from the termination date.

Employee Contributions. To the extent an active Participant does not have sufficient Benefit Credits to pay for the Benefits selected, the Employer is authorized to withhold the additional amounts from a Participant's Compensation from the Employer to the extent required to pay for said Benefits. Further, the Employer may require that such withholdings be made on a post-tax basis.

Payment of Contributions While on FMLA. A Participant who takes an unpaid leave of absence under FMLA and who elects to continue participation under this Plan shall be responsible for making the required contributions under this Plan during the period of the FMLA. The Plan Administrator in its sole discretion, as previously stated in Section II, shall determine the manner in which such payments are made. If there is more than one choice, the Participant may make a selection based on a mutual Agreement between the Employer and the Participant.

SECTION IV
Contributions

Funding. The Benefits provided shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of Compensation as a Participant elects to forego pursuant to a Compensation Reduction Agreement. If any Benefits of this Plan are insured by a third party insurer, those Benefits will be paid by the insurer or its nominee, such as a third party administrator.

Execution of Agreements. Approximately 30-days prior to the beginning of the Plan Year, the Administrator shall provide a written election form, which shall include a Compensation Reduction Agreement to each Participant and to each Employee who is expected to become an Eligible Employee by the first day of the first Plan Year, and all subsequent Plan Years. All Compensation Reduction Agreements entered into by Participants in the Plan shall be executed before the close of the Enrollment Period for the Plan Year for which such Agreements will be effective or, in the case of Participants who were not eligible to participate in the Plan at the beginning of the Plan Year, before the first day of the pay period after the Entry Date on which they become eligible to participate in the Plan. Each Compensation Reduction Agreement shall remain effective throughout the Plan Year unless revoked or suspended by reason of any Participant's ceasing to be an Eligible Employee.

No Compensation Reduction Agreement may be revoked by any Participant during the Plan Year for which it is effective, except by reason of a family status change described herein. Any Participant who fails to execute appropriate Agreements during the Enrollment Period shall be deemed to have not elected to participate in that Plan Year's election and will not be eligible for any Reimbursement Account.

Amount of Compensation Reduction. The Compensation reduction amount shall be specified by the Eligible Employee in the Compensation Reduction Agreement. Such Compensation reduction shall not exceed the amount set forth in Schedule A, B or C attached hereto. The Compensation reduction amount shall be designated on a per pay basis, as indicated.

Crediting of Compensation Reduction Amounts. All Compensation reduction amounts shall be applied to reduce the Participant's Compensation for each pay period in as nearly equal amounts as the Employer deems practicable, except as the Employer shall otherwise determine. Compensation reduction amounts shall be credited to the Participant's Benefit Credits as of the end of the pay period to which such amount is attributable, provided, however, that no person's Compensation for any pay period shall be reduced by reason of a Compensation Reduction Agreement, nor shall any Benefit Credits be credited by reason of such Agreement, if such person is not an Eligible Employee on the date as of which such Compensation is otherwise payable.

SECTION V
Administration

Administrator. The Employer shall be the Plan Administrator. The Plan Administrator's Tax ID Number is: 35-6000207. The type of Plan is a Welfare Plan and the type of Administration is Contract Administration.

The Name of this Plan is the Flexible Benefit Plan, established by the Employer, Vigo County Government, whose address is Vigo County Annex, HR Dept., 650 S. 1st Street, Terre Haute, Indiana 47807-3438. The effective date of this Plan is January 1, 2018. The Plan Administrators telephone number is (812) 462-3249.

The Employer has appointed MedBen whose address is 1975 Tamarack Rd, P.O. Box 1096, Newark, OH 43058-1096 and whose telephone number is (800) 297-1829 as Claim Administrator.

Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration, which has been delegated by the Employer, and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration. The Employer shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical, and other services to carry out the provisions of the Plan. The Employer shall pay the costs of services and other administrative Expenses.

Funding Policy. The Employer shall periodically at its discretion review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

Claims Procedure. To receive Benefits under the Plan, a Participant must submit written claims for Benefits to the Claim Administrator. The Claim Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan, he may submit a written request to the Claim Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Claim Administrator must respond to such a request within a reasonable time. Additionally, the Claim Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating, in a format determined to be understood by the claimant,

(i) the specific reason or reasons for the denial;
(ii) a description of any additional material or information necessary for the claimant to perfect the claim; and
(iii) an explanation of the claim review procedure.

Such notice will be given within 30-days after the claim is received by the Claim Administrator (or within 60-days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30-day period). If such notification is not given within such period, the claims will be considered denied as of the last day of such period, and such person may then request a review of his claim.

The Employer permits the Participant to use an electronic Debit Card. The Debit Card is usable at a merchant or service provider with a specified merchant code relating to healthcare. Every claim paid through the electronic Debit Card must be reviewed and substantiated through the submission of proper substantiation after-the-fact by the Participant. Vigo County Government does allow automatic adjudication for certain claims that meet a specific co-payment requirement. If the dollar amount of the transaction at a health care provider equals the dollar amount of the standard office visit or Prescription co-payment for that service under the Plan in which the specific Employee or Debit Cardholder participates, the charge is considered to be fully substantiated without the need for submission of a receipt or further review. All charges to the electronic Debit Card that were not automatically adjudicated are treated as conditional pending after-the-fact substantiation that they were for eligible Expenses. The Plan will not require sampling techniques based on transaction amounts.

The Participant understands that the Expenses may not be used to claim any federal income tax deduction or credit. The Participant also understands that if the Expenses are deemed ineligible for reimbursement or if the Participant fails to substantiate a Debit Card Expense under the Employer's Plan that it is the Participant's responsibility to reimburse the Plan immediately for the ineligible or unsubstantiated portion of the transaction. If the Participant fails to repay, the Employer could implement various ways to recoup the ineligible or unsubstantiated Expenses. This includes, but is not limited to:

1. withhold the amount from the Employee's Compensation on an after-tax basis, to the extent consistent with applicable law;
2. amounts outstanding could be offset (i.e. recouped) from future claims;
3. deny access to electronic Debit Card – deactivate Debit Card;
4. treat payment as other business indebtedness – include dollars in Participant's W-2 as income.

If the Debit Card is used again for an ineligible Expense, the Debit Card could be suspended for the remainder of the Plan Year or indefinitely. In this event, the Participant must obtain future reimbursements by submitting a manual request for reimbursement form along with the appropriate receipt(s).

General Benefit Exclusions and Limitations. The following exclusion apply to qualified medical expenses incurred by all eligible individuals - charges for services rendered by a Provider with the same legal residence as the Participant or who is the Participants Close Relative.

Substantiation of Claims. The IRS regulations require that an Employee furnish a written statement stating that the Expense they are requesting reimbursement on has been incurred and they have not been reimbursed nor will they seek reimbursement under the Vigo County Government Health Benefit Plan or any other health plan, Flexible Benefit plan, Health Reimbursement Arrangement Plan, or Health Savings Account plan. The Participant does not have to prove the services were paid for, they only have to prove the services were incurred during the applicable Plan Year. The Participant must provide supporting documentation from an independent third party, which includes the following:

- A bill or receipt (including date of service, name of patient, provider name and address, amount, and type of service) from a doctor, dentist or other supplier;
- A Prescription receipt (including the date Prescription was filled, name of patient, pharmacy name and address, amount, and Prescription name) from a pharmacy;
- Explanation of Benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision plan(s) under which the Employee or any eligible Dependents are covered;
- A bill or receipt which includes the date(s) of service, name of Dependent, childcare provider name, address and phone number, amount, Tax ID number or Social Security number from a childcare provider;
- Store receipts are acceptable for hearing aid batteries, contact lens solution, support braces, reading glasses, and other eligible over-the-counter items. The receipt must have the following information printed on the receipt: Store name, date of purchase, product name, and amount of product;
- To obtain reimbursement for over-the-counter drugs or medications, a copy of the Prescription for the drug or medication must be submitted either prior to or at the time of filing the claim for reimbursement.

Cancelled checks, handwritten receipts, credit/Debit Card transaction receipts, balance due, or previous balance receipts cannot be used to verify an Expense.

Claims Appeals. Participants have a right to appeal claim payment determinations. If the Participant disagrees with any claim payment determination, then said Participant must submit proof that a claim for Benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If the Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two (2) appeals of an adverse Benefit determination. The Participant will be provided, free of charge, with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 180-days following receipt of this notice, which must be in writing and addressed as follows: MedBen SSU Dept, 1975 Tamarack Rd, P.O. Box 1096, Newark OH 43058-1096, Attn: Claims

Appeals. If the Participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 30-days after receipt of the appeal. A Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for Benefits.

Nondiscriminatory Operation. All rules, decisions and designations by the Employer, Claim Administrator and each Committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel. Neither the Employer nor any of its Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

SECTION VI
Protected Health Information

The following describes how medical information about Plan Participants may be used and disclosed and how Plan Participants can get access to this information. Please review it carefully.

PROTECTED HEALTH INFORMATION (PHI) means health information that either identifies an individual, or for which there is a reasonable basis to believe it can be used to identify an individual, and which is one (1) of the following:

A. transmitted by electronic media, including:
   1. the internet;
   2. an extranet;
   3. leased lines;
   4. dial-up lines;
   5. private networks;
   6. those transmissions that are physically moved from one (1) location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium.

HEALTH INFORMATION means any information, whether oral or recorded, in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:
   1. the past, present or future physical or mental health or condition of an individual;
   2. the provision of health care to an individual; or
   3. the past, present or future payment for the provision of health care to an individual.

SUMMARY HEALTH INFORMATION means information that may be individually identifiable health information that:

A. summarizes the claims history, claims Expenses or type of claims experienced by Eligible Employees under this Plan; and
B. from which the following information has been removed:
   1. names;
   2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
   3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
   4. telephone numbers;
   5. fax numbers;
   6. electronic mail addresses;
   7. social security numbers;
   8. medical record numbers;
   9. Plan identification numbers; or
   10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

PRIVACY OF HEALTH INFORMATION. This provision is intended to bring this Plan into compliance with the privacy provisions of the HIPAA, as amended, and the regulations issued hereunder. Such procedures will be in effect for this Plan for all transactions performed on or after April 14, 2004. Health information transmitted or maintained by the Plan will be subject to the provisions described in this article.

USE AND DISCLOSURE OF PHI. PHI will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the PHI, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Section VI, including, but not limited to, the review of any grievances or appeals involved in such activities which are generated by the Participant or his authorized representatives;

C. for other reasonable purposes necessary to operate the Plan, to the extent that such PHI is required for such purposes, including:
   1. quality assessment and improvement activities;
   2. evaluation of Plan performance;
   3. underwriting and Premium Expense rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
   4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   5. business planning and development of the Plan;
   6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service, and the resolution of internal grievances; and
   7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of PHI is permitted by this Plan.

DISCLOSURES OF HEALTH INFORMATION TO THE EMPLOYER. The Plan Administrator will disclose, or permit the disclosure of, health information to the Employer only as described below:

A. for any of the purposes and under the conditions described herein;

B. as summary health information, if requested by the Employer for the following purposes:
   1. obtaining Premium Expense bids from health plans for providing health insurance coverage under the Plan; or
   2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Employer for the purpose of performing Plan administrative functions;

Prior to any disclosure of health information to the Employer, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this Section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the Employer or Plan Administrator for Plan administration or other Plan purposes to whom it provides PHI, including, but not limited to, the benefit manager, any utilization review service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the Employer with respect to such information;

C. not to use or disclose the PHI for employment-related actions and decisions, or in connection with any other Benefit or Employee Benefit plan sponsored by the Employer; and

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this Section of which it becomes aware;

E. that it will make available PHI to the subject of such information, and allow amendment to such information as described herein;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of PHI, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that Section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

H. that it will, if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and

I. that it will provide for adequate separation between the Plan and the Employer by implementing the following procedures:
   1. access to PHI will only be provided to the following categories of Employer employees:

listing of individuals/classes of individuals employed by or under the control of the Employer who receive PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business;
2. that access to and use by such employees or other persons as described above will be limited to the Plan administration functions that the Employer performs for the Plan; and
3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Employer's established Employee discipline and termination procedures.

ACCESS OF PARTICIPANTS TO PHI. A Participant has the right of access to inspect and obtain a copy of PHI about such person as long as such information is maintained by the Plan, except for:
A. psychotherapy notes;
B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or
C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator in writing and signed by the Participant whose information is being requested. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

AMENDMENT RIGHTS. A Participant has the right to have the Employer amend PHI or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:
A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
B. the information is not currently maintained in any record by the Plan;
C. the information would not be available for inspection under the reasons cited; or
D. the information in the Plan's records is accurate and complete.

Any request for amendment of PHI must be provided in writing to the Plan Administrator and signed by the Participant who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity's receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

SECURITY OF PHI. The Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Employer and the Plan to support the requirements of this Section. The Employer will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware of to the Plan Administrator.

SECTION VII
Continuation of Coverage

In General. The following provisions shall apply to Benefits provided to Eligible Employees and their Dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

Dependent Care Reimbursement Accounts do not provide health care or medical coverage therefore are not COBRA eligible Plans. COBRA continuation coverage will not be offered to a Participant enrolled in the Dependent Care Reimbursement Account.

Continuation of Coverage. A Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the Election Period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a Qualified Beneficiary who is a covered Employee or Spouse of the covered Employee will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all Qualified Beneficiaries under this Plan in connection with such group.

COBRA provides special provisions for the Medical Reimbursement Accounts. COBRA regulations provide for a special limited COBRA obligation. COBRA coverage will not be offered to Qualified Beneficiaries who have overspent their Medical Reimbursement Account as of the date of the Qualifying Event. COBRA coverage will be offered to Qualified Beneficiaries with underspent Medical Reimbursement Accounts, however continuation coverage may only continue until the end of the Plan Year in which the Qualifying Event occurs.

Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event and ending not earlier than the earliest of the following:

A. The end of the Plan Year in which the Qualifying Event occurs; or
B. The date the Qualified Beneficiary fails to pay the applicable Premium Expense.

Contribution.

A. A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable Premium Expense required by the Employer or a Participating Employer in full and in advance, except as provided in B. below. Such Premium Expense shall not exceed the requirements of applicable federal law. A Qualified Beneficiary may elect to pay such Premium Expense in monthly installments.
B. Except as provided in C. below, the payment of any Premium Expense shall be considered to be timely if made within 30-days after the date due, or within such longer period of time as applies to or under this Plan.
C. Notwithstanding A. and B. above, if an election is made after a Qualifying Event during the Election Period, this Plan will permit payment of the required Premium Expense for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

Notification by Qualified Beneficiary. Each covered Employee or Qualified Beneficiary must notify the Employer or a Participating Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's Spouse, and/or the covered Employee's Dependent child ceasing to be a Dependent child under the terms of this Plan within 60-days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occurs after the date of the enactment of the Tax Reform Act of 1986.

Notification to Qualified Beneficiary. The Employer shall provide written notice to each covered Employee and Spouse of such covered Employee of his right to continuation coverage under this provision as required by federal law.

The Employer shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered Employee from the covered Employee's Spouse or a Dependent child ceasing to be a Dependent child under the terms of this Plan, Vigo County Government shall only be required to notify a Qualified Beneficiary of his right to elect continuation coverage if the covered Employee or the Qualified Beneficiary notifies Vigo County Government of such Qualifying Event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60-days after the date of such Qualifying Event.

Notification of the requirements of this provision to the Spouse of a covered Employee shall be treated as notification to all other Qualified Beneficiaries residing with such Spouse at the time notification is made.

Definitions. The terms used in the text of Sections VI and VII are defined as follows:

"Dependent" means an individual who meets the definition of a Dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Account, Dependents will also include individuals who are Dependents within the meaning of Section 152(a) of the Code, and as defined in Section I hereof.

No person shall be considered a Dependent of more than one (1) Employee. If both an Employee and an Employee's Spouse are employed by the Employer or a Participating Employer, their Dependent children may be covered by either Spouse, but not by both.

"Election Period" means the 60-day period during which a Qualified Beneficiary who would lose coverage as a result of a Qualifying Event may elect continuation coverage. This 60-day period begins no later than the date of termination of coverage as a result of a Qualifying Event and ends no earlier than 60-days after the later of such date of termination of coverage, or the receipt of notice of the right to elect continuation coverage under this Plan.

"Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

"Qualified Beneficiary" means an individual who, on the day before the Qualifying Event for a covered Employee, is a Beneficiary under this Plan as the Dependent (as defined in Section I hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term Qualified Beneficiary includes the covered Employee. A child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary. The term Qualified Beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the Employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and Section 861(a)(3)). If an individual is not a Qualified Beneficiary pursuant to this paragraph, a Spouse or Dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

"Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a Qualified Beneficiary:
(i) the death of the covered Employee;
(ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered Employee's employment;
(iii) divorce or legal separation of the covered Employee from such covered Employee's Spouse, as herein defined;
(iv) the covered Employee becoming entitled to Benefits under Title XVIII of the Social Security Act (Medicare);
(v) a Dependent child who ceases to be a Dependent child under the terms of this Plan;
(vi) the Employer's filing for Chapter 11 reorganization, as it would affect retiree coverage.

"Overspent" means the total Employee contributions, as of the date of the Qualifying Event, are less than the total expenses reimbursed, as of Qualifying Event.

"Underspent" means the total Employee contributions, as of the date of the Qualifying Event, are greater than the total expenses reimbursed, as of Qualifying Event.

SECTION VIII
Miscellaneous

Amendment and Termination. The Employer or its authorized representative may amend or terminate this Plan at any time by action of the Board. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under Section 125 of the Code. No amendment shall deprive any Participant or beneficiary of any Benefit to which he is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the Benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

It is the intention of the Employer that should a termination of the Plan or the amendment of this Plan deprive any Participant of a Benefit Credit that exists upon such termination or amendment that the value of the accounts of the Participant exists upon that date would be paid to the Participant in full.

Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant of this Plan.

Alienation of Benefits. No Benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

Facility of Payment. If the Employer deems any person incapable of receiving Benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the Benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete

release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim. As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Status of Benefits. The Employer believes that this Plan is in compliance with Section 125 of the Code and that it provides certain Benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax Benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

Agent for Service of Legal Process. The Employer named in Section I is the Agent for Service of Legal Process. The Plan Administrator Vigo County Government may also be an Agent for Service of Legal Process.

Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Indiana to the extent not pre-empted by any federal law.

Lost Distributions. Any Benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however that such Benefit shall be reinstated if a claim is made by the Participant for the forfeited Benefit.

Source of Payments. The Employer and any Employer contracts purchased or held by the Employer shall be the sole sources of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Heirs and Assigns. This Plan shall be binding upon the heirs, executors, Administrators, successors, and assigns of all parties, including each Participant and beneficiary.

Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not payments received by a Participant under the Plan will be treated as includible in gross income for federal or state income tax purposes.

Multiple Functions. Any person or a group of persons may serve in more than one (1) fiduciary capacity with respect to the Plan.

Indemnification of Employer. If any Participant receives one (1) 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.

No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than for the exclusive Benefit of Plan Participants or their beneficiaries, or for defraying reasonable Expenses of administering the Plan.

Prior Year Claims. Reimbursement claims may be submitted up to three (3) months past the end of the Plan Year or the date of the Participants termination from the Plan, whichever comes first.

Flexible Benefit Plan Document

Attest: IN WITNESS WHEREOF, the Vigo County Government Flexible Benefit Plan adopted, by execution hereof, effective as of January 1, 2018.

Vigo County Government

Executed this Date: 05 / 22 / 2018

By: Judith A. Anderson (Authorized Officer)

Vigo County Government Flexible Benefit Plan
Plan Document

SCHEDULE A

Schedule of Benefits
Medical Reimbursement Account

Pay Period for Annual Payroll Contributions: bi-weekly

Employee Annual Contribution Limitations:	**Maximum**
Health Care Spending	$2,650.00

Services must be incurred in order to receive reimbursement from this Account. Expenses are considered to be incurred the day the service is rendered, not when a Participant is billed, charged or pays for the service. Reimbursements made during a Plan Year are only made for eligible Expenses incurred during that same Plan Year.

Examples of Expenses for which a Participant may be able to receive reimbursement include:

- Medical and dental Expenses not covered under any other plan,
- Deductibles, co-payments and co-insurance that Participants are responsible for under their primary medical, dental or vision plan, or under any other plan,
- Prescription drugs and medications (including over-the-counter drugs or medicines as long as it is prescribed and there is a written or electronic order for a medicine or drug that meets the legal requirements of a Prescription in the state in which the medical Expense is incurred and that is issued by an individual who is legally authorized to issue a Prescription in that state),
- Eye exams, eyeglasses, contact lenses, and other vision Expenses,
- Orthodontic Expenses,
- Hearing exams, hearing aids, other hearing Expenses,
- Physical therapy (not massage therapy),
- Chiropractics,
- Acupuncture, and
- Psychotherapy.

Examples of Expenses for which a Participant may not be reimbursed include:

- Custodial care,
- Health insurance premiums that a Participant or their spouse pays for coverage under another health plan,
- Costs for sending a child to a special school for Benefits the child may receive from the course of study and disciplinary methods,
- Health club dues,
- Social activities, such as dance lessons ,
- Bottled water,
- Maternity clothes,
- Diaper service or diapers,
- Cosmetics, toiletries, toothpaste, etc.,
- Vitamins taken for general health purposes, and
- Cosmetic surgery or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. Cosmetic surgery means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevents or treats illness or disease.

Vigo County Government Flexible Benefit Plan
Plan Document

SCHEDULE B

Schedule of Benefits
Dependent Care Reimbursement Account

Pay Period for Annual Payroll Contributions: bi-weekly

Employee Annual Contribution Limitations:	**Maximum**
Dependent Care Spending	$5,000.00*

Services must be incurred in order to receive reimbursement from this Account. Expenses are considered to be incurred the day the service is rendered, not when a Participant is billed, charged or pays for the service. Reimbursements made during a Plan Year are only made for eligible Expenses incurred during that same Plan Year.

* A Participant who is married at the close of a Plan Year may not receive reimbursement for eligible Expenses incurred by him for the Plan Year in excess of the lesser of:

A. $5,000 (or $2,500 in the case of a married Participant filing a federal income tax return separate from his Spouse);
B. his Compensation for such Plan Year;
C. the Compensation of his Spouse for such Plan Year; or
D. the Benefit Credits allocated to a Participant's account for the Plan Year.

A Participant who is not married at the close of a Plan Year may not receive reimbursement for eligible Expenses incurred by him for the Plan Year in excess of the lesser of $5,000 or his Compensation for the Plan Year. Notwithstanding the above, the maximum reimbursement paid under this Plan must also be reduced by the amount of any tax-exempt Dependent Care Reimbursement Account Benefits received by the Participant or his Spouse from any other employer during the Plan Year.

Vigo County Government Flexible Benefit Plan
Plan Document

SCHEDULE C

Schedule of Benefits
Premium Conversion Account

Pay Period for Annual Payroll Contributions: bi-weekly

Benefit Programs	Coverage Tiers	Employee Contributions
Health Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child(ren)	Included
	Employee & Family	Included
Prescription Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child(ren)	Included
	Employee & Family	Included
Dental Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child(ren)	Included
	Employee & Family	Included
Vision Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child(ren)	Included
	Employee & Family	Included
AFLAC Policies	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child(ren)	Included
	Employee & Family	Included

The Employee contributions necessary to obtain the coverage options set forth in this Schedule will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period. The necessary form is called a Compensation Redirection Agreement. Required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option provided above.

There are no other Employers Affiliated with this Plan.