AMENDED AND RESTATED
CAFETERIA PLAN
with
FLEXIBLE SPENDING ARRANGEMENT

PROVIDED BY

Metropolitan Government of Nashville & Davidson County

Amended and Restated Effective January 1, 2015

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ARTICLE 1. ESTABLISHMENT AND PURPOSE

1.1 Establishment. Metropolitan Government of Nashville & Davidson County establishes, effective as of April 1, 1992, a cafeteria plan for the benefit of its employees who may participate in the Plan. The Plan shall be known as the **Metro Nashville Employee Flexible Benefits Plan**.

1.2 Purpose. The purpose of the Plan is to provide Employees who may participate in the Plan the choice between cash and different combinations of health, dependent care and other benefits as specified in the Plan. The Plan is established in accordance with the provisions of Section 125 of the Internal Revenue Code and other applicable provisions.

1.3 Qualified Status. The Plan is intended to meet the requirements of Section 125 of the Internal Revenue Code and shall be interpreted and administered in accordance with the requirements of that section.

ARTICLE 2. DEFINITIONS

2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning.

(a) Change in Status, means a Change in Status, as defined in Section 4.2(b)(2) of this Plan.

(b) COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

(c) Code or IRC means the Internal Revenue Code ("IRC") of 1986, as amended.

(d) Committee means the Metropolitan Employee Benefit Board, or such other person or Committee as may be appointed by the Metropolitan Employee Benefit Board to supervise the administration of the Plan in accordance with the provisions of Article 10.

(e) Compensation of a Participant means the total of amounts paid to a Participant by the Employer and reported on the Participant's Federal Income Tax Withholding Statement (form W-2) including pre-tax contributions under this Plan, contributions under any plan maintained by the Employer pursuant to Section 457 of the Code and pre-tax contributions for qualified transportation fringe benefits under Section 132 of the Code, benefits, but excluding all other fringe benefits.

(f) Contract Administrator means an administrator that has contracted with the Employer to provide administrative services under the Plan. This term is not the same and is not intended to have the same meaning as the term defined in section 3(16) of ERISA.

(g) Dependent Care Assistance Account means the account established under Section 7.1 for each Participant, as increased under Section 7.2 by allocated Pay Conversion Contributions and as decreased under Section 7.3 by benefit payments made to the Participant.

(h) Effective Date means April 1, 1992, the date on which the Plan became effective. The Effective Date of this amendment and restatement shall be January 1, 2013.

(i) Eligible Employee means an Employee who is described as an Eligible Employee under the terms of the Metropolitan Nashville and Davidson County Self-Insured Medical PPO Plan or the Metropolitan Nashville and Davidson County Self-Insured Account Based Plan, based on whichever plan such Employee is a Participant and who qualifies as an employee under section 13.07 of the Metropolitan Charter. The term Eligible Employee shall also include an Elected Official that qualifies as an employee under section 13.07 of the Metropolitan Charter. Eligible Employee shall include an actively serving member of the Metropolitan Council ("Council Member") provided that such Council Member elects to participate in this Plan when first eligible to do so, or during an annual enrollment and who, by such election, agrees to be bound by the terms and conditions of the Plan. For purpose of any service requirement, in terms of hours and/or months, periods that an Employee is on leave required under FMLA or during an absence from work for duty in the uniformed services of the United States of America shall be counted.

(j) Employee means a person who is employed by the Employer as an employee under the common law and/or statutes of the State of Tennessee and who receives Compensation from the Employer. The Term Employee shall include an Elected Official. Employee status shall not be considered to be affected by a leave of absence that is Employer-approved or legally required. However, the term Employee shall not include any person employed by the Employer at a location outside the United States or an individual characterized by the Employer as an independent contractor or leased employee.

(k) Employee Benefit Election Form means the form described in Section 3.2.

(l) Employer means **Metropolitan Government of Nashville & Davidson County** or its successor(s) and any other agency, district or other public entity associated with the City of Nashville and/or Davidson County which, with the consent of the Metropolitan Government of Nashville & Davidson County adopts the Plan for some or all of its Employees; provided that any entity whose adoption of the Plan would cause the Plan not to be a "governmental plan" as defined in Section 414(d) of the Code may not be an Employer.

(m) Employment-Related Dependent Care Expense means an amount paid by a Participant for household services or for the care of a Qualifying Individual, to the extent that such expense is incurred to enable the Participant to be gainfully employed for any period for which there is one or more Qualifying Individuals with respect to the Participant.

However, (1) if such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Individual who is a IRS Tax Qualified Dependent of the Participant as defined in Section 21(b)(1) of the Code or for a Qualifying Individual who regularly spends at least eight hours per day in the Participant's household; (2) if the expense is incurred outside the Participant's home at a facility which is a dependent care facility as described in Section 21(b)(2)(D) of Code (dealing with expenses for household and dependent care services necessary for gainful employment) that provides care for more than six individuals who do not regularly reside at such facility, such facility must comply with all applicable licensing requirements, if any; and (3) Employment-Related Dependent Care Expenses of a Participant shall not include expenses paid or incurred for services provided by (i) a child of such Participant who is under the age of 19 or (ii) an individual who is an IRS Tax Qualified Dependent of such Participant or such Participant's spouse. The term Employment-Related Dependent Care Expense shall not include any amount paid for services outside the taxpayer's household at a camp where the Qualifying Individual stays overnight.

(n) FMLA Leave means a leave of absence provided to an Employee of the Employer under the Family and Medical Leave Act of 1993, as amended.

(o) Health Care Expense means an expense related to the diagnosis, cure, mitigation, treatment, or prevention of disease consisting of expenses for medical care within the meaning of Section 213(d) of the Code, including, but not limited to, payments for the purpose of affecting any structure or function of the body, or for any hospital or nursing charges, optometric, ophthalmological or auditory care, routine physical examinations, well-baby care, dental and orthodontic care, psychiatric care, prescription drugs, over-the-counter drugs which qualify as medical expenses under Section 213(d) of the Code and the regulations thereunder, insulin, eyeglasses or contact lenses, hearing-aid appliances, similar prosthetic devices, medical-related transportation or medical or dental insurance out-of-pocket expenses.

The term "Health Care Expense" does not include cosmetic surgery or other similar procedures, 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. The term cosmetic surgery means any procedure, which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

The term "Health Care Expense" shall also include expenses for orthodontia services paid by a Participant before the services are provided but only to the extent that the employee has actually paid such expenses in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when the employee makes the advance payment. Orthodontia services shall not be deemed to be cosmetic procedures for purposes of the preceding paragraph.

(p) Health Care Expense Account means the account established under Section 6.1 for each Participant, as increased under Section 6.2 by allocated Pay Conversion Contributions and as decreased under Section 6.3 by benefit payments made to the Participant.

(q) Highly Compensated Employee means a highly compensated individual or participant as defined in Code Section 125(e); a highly compensated employee as defined in Code Section 129(d)(2); or a highly compensated individual as defined in Code Section 105(h)(5).

(r) Insurance Plan means the plan(s) maintained by the employer to provide accident and health benefits to Employer's Employees.

(s) IRS Tax Qualified Dependent means:

(1) With respect a Premium Only Option, one of the following individuals:

(i) Legally recognized spouse of an Eligible Employee in accordance with the laws of the State of Tennessee, while not divorced or legally separated from the Eligible Employee.

(ii) Domestic partner and his or her children who are Internal Revenue Service ("IRS") Tax Qualified Dependents of the Eligible Employee as outlined in the Domestic Partnership Benefits Policy approved by the Benefit Board and where a Declaration of Domestic Partnership has been completed and acknowledged by Metro Human Resources. The IRS Tax Qualified Dependent criteria must be applied to domestic partner and/or the domestic partner's dependents separately, in accordance with IRC provisions and U.S. Department of Treasury Regulations, as follows:

a. He/she lives with the Eligible Employee as a member of the Eligible Employee's household for the full tax year, except for temporary reasons such as vacation, military service, or education.
b. He/she is related to the Eligible Employee as follows:
    i. A child or descendant of a child (IRC Section 152(d)(2)(A)); or
    ii. An individual (other than an individual who at any time during the taxable year was a spouse, determined without regard to IRC 7703, of the Eligible Employee) who for the taxable year of the Eligible Employee, has the same principal place of abode and is a member of the Eligible Employee's household (IRC Section 152(d)(2)(H)).
c. He/she is a citizen, national or legal resident of the United States or a resident of a contiguous country (IRC Section 152(b)(3)(A)). This requirement doesn't apply to children being adopted by a US Citizen or national (IRC Section 152(b)(3)(B)).
d. He/she receives more than half of his or her support from the Eligible Employee (IRC Section 152(d)(1)(C)).
e. He/she isn't anyone else's Section 152 qualifying child dependent (IRC Section 152(d)(1)(D)).

(iii) Natural and adopted children of an Eligible Employee who may or may not reside in the home of the Eligible Employee the majority of the time on an annual basis.

(iv) Foster children placed with an Eligible Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

(v) A child of an Eligible Employee or Employee's spouse/domestic partner for whom a Qualified Medical Child Support Order has been issued.

(vi) Step-children of an Eligible Employee or children, other than those listed above, who are in the Eligible Employee's legal custody by court order and are the Eligible Employee's IRS Tax Qualified Dependent.

(vii) IRS Tax Qualified Dependent children, as defined above, will be covered from birth until the last day of the month of their 26th birthday, married or unmarried.

(viii) If, on a child's 26th birthday, he or she is incapacitated and is an individual who qualifies as a dependent under the provisions of Section 152 of the Code (determined without regard to Section 152(b)(1), (b)(2) and (d)(1)(B)) and is unable to sustain full time employment by reason of a mental retardation or physical handicap, the child shall continue to be deemed an IRS Tax Qualified Dependent during the continuation of the incapacity and while he or she is otherwise included as an IRS Tax Qualified Dependent under this subsection, subject to the other terms and conditions of the Plan and the right of the Committee to require proof of the incapacity at such times as they may reasonably require.

(2) With respect to the Health Care Reimbursement Plan, an individual who qualifies as a dependent under the provisions of Section 152 of the Code (determined without regard to Section 152(b)(1), (b)(2) and (d)(1)(B)). For purposes of the Health Care Reimbursement Plan, the term "IRS Tax Qualified Dependent" includes a child of the Eligible Employee or his or her spouse/domestic partner who is otherwise an IRS Tax Qualified Dependent under this section and who is entitled to coverage under a qualified medical child support order.

(3) Solely with respect to the Dependent Care Assistance Plan, the term "IRS Tax Qualified Dependent" shall mean a "Qualifying Individual" as defined herein.

(t) Participant means a person who is an Eligible Employee on or after the Effective Date, who applies to participate in the Plan, and who satisfies the participation conditions of Article 3.

(u) Pay Conversion Contributions means the contributions of a Participant made by salary reduction agreement in accordance with Section 4.1.

(v) Period of Coverage, with respect to any Plan Year, means that Plan Year. However, for any Employee:

(1) Who becomes a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the effective date of the Participant's participation and extending through the remainder of the Plan Year, or

(2) Who ceases being a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the first day of the Plan Year and extending through the last day of the earlier of (i) the Participant's participation, or (ii) the Plan Year.

A Period of Coverage is the period during which elections made pursuant to Article 4 are effective and elected benefits described in Articles 5, 6 and 7, as applicable, are provided.

(w) Plan means the **Metro Nashville Employee Flexible Benefits Plan** as amended or restated from time to time.

(x) Plan Year means each twelve-month period ending **December 31**.

(y) Premium Only Option means the option to pay insurance plan premiums on a pre-tax basis through the Plan.

(z) Qualifying Individual means (i) an IRS Tax Qualified Dependent of a Participant as defined in Section 21(b)(1) of the Code (dealing with expenses for household and dependent care services necessary for gainful employment); or (ii) an IRS Tax Qualified Dependent child (including the child of a domestic partner that satisfies the IRS Tax Qualified Dependent criteria for the Participant).

2.2 Gender and Number. Except as otherwise indicated by context, masculine terminology also includes the feminine, and vice versa, and terms used in the singular may also include the plural.

ARTICLE 3. PARTICIPATION

3.1 Participation Conditions. As a condition of participation and receipt of benefits under this Plan, each Participant shall be required to:

(a) Furnish to the Committee a completed Employee Benefit Election Form along with required documentation

(b) Designate and apply a portion of his or her Compensation as Pay Conversion Contributions in accordance with the provisions of Article 4

(c) Observe all Plan requirements, rules and regulations

(d) Consent to inquiries by the Committee with respect to any physician, hospital or other provider of health care or other services involved in a claim under this Plan

(e) Submit to the Committee all reports, bills and other information that the Employer may reasonably require

(f) Be an Employee and an Eligible Employee; provided however, that Elected Official that qualify as employees under section 13.07 of the Metropolitan Charter and Council Members shall not be eligible to participate in the Health Care Reimbursement Plan or the Dependent Care Assistance Account.

3.2 Application to Participate. As a condition of participation, each Eligible Employee shall complete, sign and deliver to the Committee an Employee Benefit Election Form within 30 days of his or her date of employment or reemployment and, except as provided in the last paragraph of Section 4.2, during each open enrollment period applicable to subsequent Plan Years. It is by this form that the Eligible Employee applies to participate in the Plan, designates the required portion of his or her Compensation for that Plan Year as Pay Conversion Contributions, makes a benefit election, and supplies any other pertinent information that the Committee reasonably requires. Unless otherwise required by the Committee, the application shall be delivered to the Committee prior to the first day of an Employee's participation. Notwithstanding anything in this Plan to the contrary, the Employer may make available electronic media which satisfies the requirements of Treas. Reg. Section 1.125-2 and 1.401(a)-21 with which Participants may make one or more elections allowed under the Plan and any Participant's election using such electronic media shall be treated for all purposes of the Plan as a signed Employee Benefit Election Form delivered to the Committee. Paper Employee Benefit Election forms shall be made available to any employee who does not have reasonable access to such electronic media.

3.3 Default Coverage. In the event an Eligible Employee shall fail to elect coverage for a Period of Coverage within the time prescribed under a Premium Only Option which provides medical benefits (including coverage for prescription drugs) and dental benefits such Eligible Employee shall automatically be covered under the Metropolitan Nashville and Davidson County Self-Insured Medical PPO Plan for such Period of Coverage and the Dental PPO under the Metropolitan Government of Nashville & Davidson County Insured Dental Plan. Failure to make such an election shall be deemed an election by such Eligible Employee of such plans and an authorization for the Employer to deduct Pay Conversions from his or her Compensation in an amount required to pay such Eligible Employee's Pay Conversion Contributions. IRS Tax Qualified Dependents of such Eligible Employee shall have no coverage under any health plan or dental plan which is offered hereunder for such Period of Coverage. If an Eligible Employee shall fail to elect coverage under any plan offered hereunder providing any other types of benefits for a Period of Coverage, neither the Eligible Employee nor any of his or her IRS Tax Qualified Dependents shall have any coverage under such plan or plans for such Period of Coverage.

3.4 Commencement of Participation. After an Eligible Employee satisfies the participation requirements of this Article 3, the Eligible Employee may become a Participant the latter of:

(a) **First of the Month** following **30** days of employment.

(b) Immediately following the date on which the Committee receives the Participant's signed Employee Benefit Election Form or an election is made using electronic media as described in Section 3.2.

3.5 Cessation of Participation. Participation in the Plan will end at the time that an individual ceases to be a Participant as defined in Section 2.1. With respect to periods following the date participation otherwise ends, Pay Conversion Contributions will cease but coverage may continue for the remainder of the period of coverage with respect to which the required premium has been paid.

3.6 Reinstatement Pursuant to Court Order.

(a) If an Employee whose employment is terminated for disciplinary reasons shall be reinstated to employment by an order of a court or other authority with jurisdiction over the employment status of an Employee, such Employee shall have the insurance coverage described in Section 5.1 which was in effect on the date his or her employment was so terminated and reinstated. If the effective date of such reinstatement of coverage shall be prior to the date the Employee returns to work, such Employee must pay any contributions required for such coverage which otherwise would have been due between the date his or her coverage ceased because of such disciplinary termination and the date such employee returns to work. The effective date of such coverage reinstatement shall be the applicable date described below:

(i) The date specified in such order, or

(ii) If no date is specified in such order, the date such employee returns to work, or

(iii) If the reinstatement is determined under subparagraph (a) above, and such date is prior to the date such Employee returns to work, such Employee may elect to have his or her coverage reinstated effective as of the date he or she returns to work. Such election shall be made in accordance with Section 3.2

(b) If Employee described in subsection (a) is participating in either or both the Health Care Reimbursement Plan and the Dependent Care Assistance Plan at the time his or her employment terminates, and such Employee's employment shall be reinstated during the same Plan Year in which his or her employment terminated, such employee may elect, in accordance with Section 3.2 to have his or her coverage reinstated as of the effective date of his or her coverage reinstatement. With respect to the Health Care Reimbursement Plan, the maximum reimbursement for the Plan Year shall be equal to the maximum reimbursement elected by the Participant the upon initial participation during the Plan Year, reduced by a fraction equal (i) the number of months for which the participant made and is expected to make during such Plan Year, divided by (ii) 12. With respect to both the Health Care Reimbursement Plan and the Dependent Care

Assistance Plan, no claims incurred during the period in the Plan Year for which no contributions are made by the Employee shall be reimbursed.

ARTICLE 4. PAY CONVERSION AND BENEFIT ELECTIONS

4.1 Pay Conversion. Each Participant shall designate a portion of his or her Compensation for each Plan year to be applied as Pay Conversion Contributions. The portion shall be specified by the Participant at the time that a benefit election is made under Section 4.2 on the Employee Benefit Election Form. However, the minimum for the Health Care FSA is **$20.00 per month** and the minimum for the Dependent Care FSA is **$20.00 per month** and the maximums are as follows:

(a) The maximum annual contribution per Participant to pay for insurance premiums under Article 5 shall be the actual cost of such premium payments.

(b) The maximum annual contribution per Participant to this Health Care Reimbursement Plan under 6.1 shall be **$5,000.00**. Effective January 1, 2013, the maximum annual contribution per Participant to this Health Care Reimbursement Plan under 6.1 shall be **$2,500**. For plan years beginning after December 31, 2013, the maximum annual contribution shall be increase by a cost of living adjustment in accordance with Code Section 125(i)(2)(B) as published by the U.S. Department of the Treasury or the Internal Revenue Service.

(c) The maximum annual contribution per Participant to his or her Dependent Care Assistance Account under Section 7.1 shall be the lesser of: (i) **$5,000.00** (with respect to a calendar year), or, instead, $2,500.00 (with respect to a calendar year) if a Participant is married and files a separate Federal income tax return for that year; (ii) the Participant's earned income or (iii) the spouse's/domestic partner's earned income, if applicable.

The Employer may, if necessary, adjust the rate to account for benefit election adjustments prescribed by Article 5. Except as otherwise provided by the Employer, Pay Conversion Contributions shall reduce the Participant's Compensation ratably on each pay day beginning on or after the first day of the Participant's participation, and shall continue in effect until changed in accordance with Section 4.2.

4.2 Benefit Elections.

(a) Each Participant shall make a benefit election, in the manner provided in the Plan, to apply his or her Pay Conversion Contributions during each Plan Year, in such proportions as he or she chooses, to the following:

(1) To pay the Participant's premiums for Employer-sponsored health care insurance and other insured Employer-sponsored plans, as set forth in Article 5

(2) To apply to the Participant's Health Care Expense Account for that Plan Year in accordance with Article 6

(3) To apply to the Participant's Dependent Care Assistance Account for that Plan Year in accordance with Article 7

A Participant's initial benefit election shall be made as part of his or her application to participate under Section 3.2. An election of a benefit described in Section 5.1 shall remain in effect, and deemed an election with respect to subsequent Plan Years, until changed in accordance with this Section. A Participant may change her benefit election for a subsequent Plan Year by providing written notice to the Employer on a new Employee Benefit Election Form prior to the first day of the Plan Year for which such change is to be effective in accordance with rules prescribed by the Committee. Elections respecting the Health Care Reimbursement Plan and the Dependent Care Assistance Plan must be made each year.

(b) A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except that:

(1) The Employer may limit a Participant's contributions in accordance with Section 8.2

(2) **Change in Status**

(A) If the Participant has a Change in Status (as defined in Subsection (B) below), he shall be entitled to revoke or modify his benefit election in a manner that is consistent with such Change in Status (as defined in Subsection (C) below), by providing written notice to the Committee within 60 days of the status change. An authorized change in the Participant's benefit election due to a Change in Status shall be effective **immediately** following **0** days after the date the Change in Status occurs; provided however, that any change in Pay Conversions associated with such election change shall be effective on the date of the benefit election; provided that any such Pay Conversion amounts shall be deducted from Compensation beginning with the first pay date immediately following the date on which the Committee receives the Participant's written notice. In the event that such first pay date shall be after the first pay date in January, any amounts required to be contributed pursuant to such benefit election attributable to the preceding plan year shall be made by the Employee on an after-tax basis.

(B) A Change in Status is an event that falls into one of the following categories:

(i) Legal Marital Status changes: including marriage, death of spouse, divorce, legal separation and annulment.

(ii) Domestic Partnership Status changes: including domestic partner meets eligibility guidelines, death of domestic partner, or termination of domestic partnership.

(iii) Changes in Number of IRS Tax Qualified Dependents: including birth, death, adoption or placement for adoption.

(iv) Employment Status changes of the Participant or the Participant's spouse/domestic partner or IRS Tax Qualified Dependents: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave of absence, change of work-site or change in employment status.

(v) IRS Tax Qualified Dependent Satisfies or Ceases to Satisfy the Requirements for IRS Tax Qualified Dependents: change in student status or IRS Tax Qualified Dependent no longer qualifies because of age.

(vi) Change in Residence: change in place of residence of the employee, spouse/domestic partner or IRS Tax Qualified Dependent.

(C) For accident or health coverage, the election change is consistent with the Change in Status only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan.

For other qualified benefits, the election change is consistent with the Change in Status only if it meets one of the following conditions:

(i) The election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan.

(ii) The election change is on account of and corresponds with a change in status that affects expenses described in IRC Section 129 with respect to the Dependent Care FSA.

The consistency rule of this Subsection shall be interpreted in accordance with the Special Consistency rules of applicable law.

(3) **Special Events**

(A) A Participant may revoke or modify his benefit election during the current Plan Year if the revocation or modification is on account of a

Qualified Medical Child Support Order (QMCSO) or other Judgments or Orders under 29 USC Section 1169(a); on account of the special enrollment rights of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); on account of an employee, spouse/domestic partner or IRS Tax Qualified Dependent becomes entitled to coverage under Part A or Part B of Medicare or Medicaid or on account of a COBRA Qualifying Event.

(B) A Participant, on account of an unpaid FMLA Leave, may revoke his benefit elections. When he returns from unpaid FMLA Leave after having revoked his benefit elections on account of taking FMLA Leave he may have his benefit elections reinstated on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. A reinstated Participant shall not have a greater right to benefits for the remainder of the Plan Year than a Participant who is continuously working during the Plan Year; provided however that with respect to the Health Care Reimbursement Plan, if a Participant who elected to revoke his or her election under such plan upon commencement of the leave and elects not to make contributions to such FSA during the period of leave pursuant to Section 4.3(d) or who chooses upon return from such leave to resume health FSA coverage at a level that is reduced, the maximum reimbursement under such plan is prorated for the period during the FMLA leave for which no premiums were paid.

(C) Individuals who are on an approved leave as a result of a short term disability, as well as individual's on military leave pursuant to Article 13 who elect not to contribute to the health FSA during the period of leave pursuant to Section 4.3(d) the maximum reimbursement under such plan is prorated for the period during the FMLA leave for which no premiums were paid.

(4) **Cost/Coverage Changes**

(A) Cost Changes

(i) The Employer may modify a Participant's contribution in accordance with the automatic adjustment in Section 5.2.

(ii) If the cost of coverage of an Employer-sponsored Plan described in Section 5.1 significantly increases, a Participant who is covered under that Employer-sponsored Plan may choose to pay the increased premium or revoke coverage under the plan for which the premiums are being increased and elect coverage under a plan providing similar coverage, if available.

(iii) With respect to a Dependent Care Assistance Plan under Article 7, a Participant may modify a benefit election if the cost for service provided by a dependent care provider, who is not a relative of the Participant, increases or decreases.

(B) Coverage Changes

(i) If coverage provided under a plan described in Section 5.1 or Article 7 is significantly curtailed or ceased, a Participant who is covered under that plan shall be entitled to change his benefit election by revoking coverage under the plan being curtailed or ceased and elect coverage under a plan providing similar coverage, if available.

(ii) If during a period of coverage, a new benefit plan is added (or eliminates an existing plan), a Participant may elect the new benefit plan (or elect another benefit plan if an option has been eliminated) and make a corresponding election change with respect to other plans providing similar coverage.

(iii) A Participant may make a change in such Participant's benefit election if such change is on account of and corresponds with a change made under the plan of the Participant's spouse/domestic partner, former spouse/domestic partner or IRS Tax Qualified Dependent and either (a) such change is permitted under the cafeteria plan (or qualified benefit plan) of such spouse/domestic partner, former spouse/domestic partner or IRS Tax Qualified Dependent and Code requirements applicable to such change; or (b) this Plan permits participants to make an election for a period of coverage which is different from the period of coverage under the cafeteria plan (or qualified benefit plan) of the spouse/domestic partner, former spouse/domestic partner or IRS Tax Qualified Dependent.

(C) This Section 4.2(b)(4) does not apply to an election change with respect to the Health Care Reimbursement Plan described in Article 6.

(5) A Participant who separates from the service of the Employer during a period of coverage may revoke existing benefit elections and terminate the receipt of benefits for the remaining portion of the period of coverage. If the Employee should return to service within 30 days for the Employer during the same plan year, the Employee shall reenroll with the same benefit elections prior to termination for the remaining portion of the period of coverage. If the Employee should return to service of the Employer after 30 days, but during the same plan year, the Employee may **Re-Enroll with a New Benefit Election** for the remaining portion of the period of coverage.

4.3 Contribution during Leave. With respect to Participants who go on a leave of absence which is unpaid FMLA Leave, Employer-approved leave as a result of short term disability or military leave pursuant to Article 13, contributions required or permitted to be made by them under the Plan may be made by one of the following methods, which must be nondiscriminatory and elected by the Participant before the commencement of the leave of absence or the applicable coverage period:

(a) Contributions may be made by the Employee on leave on a regular basis (generally on an after-tax basis)

(b) Contributions may be made by the Employee on leave by pre-payment (generally on a pre-tax basis with respect to the same Plan Year during which the leave occurs)

(c) Contributions advanced by the Employer on behalf of an Employee on leave may be re-paid by the Participant when he or she returns from leave on either a pre-tax with respect to the same Plan Year during which the leave occurs or on an after-tax basis.

(d) Such Participant may elect to revoke his election of coverage during the period of such leave and elect to have such coverage reinstated upon return from leave and in such case, shall not be required to make any contributions to such coverage during the period of the leave.

The coverage of Participants on leaves of absence not described above shall continue until the Employee has gone two consecutive pay periods without the full amount of the required employee contribution being withheld from his or her pay. Coverage under the plan will terminate on the date such second pay check is issued. COBRA coverage, if elected, will be effective as of the date the Employee's coverage under the plan terminates. Thereafter, such Participants may continue health coverage by electing coverage under COBRA (i) as provided in the applicable group health plan under with such Participant was covered and (ii) as provided in Section 6.7 respecting coverage under the Health Care Reimbursement Plan.

ARTICLE 5. INSURANCE PREMIUMS

5.1 Coverages. To the extent a Participant so elects, a portion of the Participant's Pay Conversion Contributions shall be used to pay the Participant's share of the cost of coverage (single or family coverage, whichever applies) under the following Employer-sponsored Plans:

(i) **Metropolitan Government of Nashville & Davidson County Self-Insured PPO Plan;**

(ii) **Metropolitan Government of Nashville & Davidson County Self-Insured Account Based Plan;**

(iii) **Metropolitan Government of Nashville & Davidson County Insured Vision Plans; and**

(iv) **Metropolitan Government of Nashville & Davidson County Insured Dental Plans.**

The benefit description in each of those plans is incorporated by reference into this Plan. The terms and conditions of each of those plans shall govern the provision of benefits under each plan.

5.2 Automatic Adjustments. If during the Plan Year the cost of Employer-sponsored Plans described in Section 5.1 which is selected by a Participant changes and the change is not significant, the Participant's benefit election shall, with respect to premium payments for that health plan, automatically be adjusted to reflect such change. A Participant shall not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided in Article 4.

ARTICLE 6. HEALTH CARE REIMBURSEMENT PLAN

6.1 Health Care Expense Accounts. The Committee shall establish for each Participant who elects the benefit option under this Article 6 a Health Care Expense Account for each Plan Year. Each Health Care Spending Account shall contain zero dollars ($0.00) initially and at the commencement of each Plan Year.

6.2 Increases in Health Care Expense Account. A Participant's Health Care Expense Account for a Plan Year shall be increased at the beginning of such Plan Year by the total amount of the Participant's annual Pay Conversion Contributions determined in accordance with Section 4.1(b) for that Plan Year that he has elected to apply toward his Health Care Expense Account in accordance with Section 4.2.

6.3 Decreases in Health Care Expense Account. The balance in a Participant's Health Care Expense Account for a Plan Year shall be reduced by the amount of any benefits paid to a Participant under Section 6.4.

6.4 Health Care Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 6 and who incurs Health Care Expenses attributable to himself, his spouse/domestic partner or his IRS Tax Qualified Dependents during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount of the Participant's benefit election for the Health Care Expense Account for that Plan Year.

6.5 Reimbursement Procedures. In order to receive reimbursement for health care expenses under this Article 6:

(a) The Participant must complete a Claim Form, attach (i) an itemized billing statement from the health care provider, (ii) an explanation of benefits from the Participant's insurer or (iii) other satisfactory proof of claim, as may be required pursuant to regulations issued by the U.S, Treasury Department, and forward the documents to the

Administrator. The Participant must provide additional information reasonably requested by the Administrator.

(b) A request for reimbursement must relate to Health Care Expenses incurred during the Participant's period of coverage. For this purpose, the term "incurred" refers to when the health care services were provided. In no event may claims incurred in one plan year be submitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) A request for reimbursement for Health Care Expenses incurred during a Plan Year must be received by the Administrator either during the Period of Coverage or on or before 90 days following the Period of Coverage.

(d) Reimbursement, if made, shall be made by the Administrator directly to the Participant, upon which the Employer, the Plan, and the Administrator shall be relieved of all further responsibility with respect to the expenses reimbursed.

Upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Article 5 or from any other source and such item will not be used as a deduction under Section 213 of the Code.

(e) The Employer may establish a minimum reimbursement amount.

6.6 Limitations on Health Care Benefits. Despite the provisions of this Article 6, no benefits shall be paid under this Article:

(a) If and to the extent that such reimbursement or payment is covered under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whomever maintained. In the event that there is such a policy or plan in effect providing for such reimbursement or payment, in whole or in part, then to the extent of the coverage under such policy or plan, the Employer and the Plan shall be relieved of any liability.

(b) To the extent that an expense has been submitted for reimbursement from a Participant's Dependent Care Assistance Account.

(c) For any expenses incurred for medical insurance premiums.

6.7 Continuation of Health Care Coverage. To the extent required by COBRA, a qualified beneficiary who would lose Health Care coverage under the Plan upon the occurrence of a qualifying event shall be permitted to continue Health Care coverage under the Plan by electing to pay the applicable premiums, on an after-tax basis, in accordance with procedures established by the Committee. The Employer shall provide notice to each covered Employee and spouse/domestic partner of their rights under COBRA in accordance with applicable law and the regulations thereunder.

6.8 Additional Requirements for Group Health Plans. The Health Care Reimbursement Plan shall be interpreted and administered so as to provide coverage, under written procedures established by the Administrator, with respect to individuals for which coverage is required by applicable law.

6.9 Separate Written Plan. For purposes of the Code, this Article shall constitute a separate written plan providing for the reimbursement of Health Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 6.

6.10 The 2 Month and 15 Day Grace Period. Notwithstanding anything else in the Plan to the contrary, expenses for Health Care Expenses incurred during the Grace Period may be paid or reimbursed from dollars in the Health Care Expense Account remaining unused at the end of the immediately preceding Plan Year. During the Grace Period, Health Care Expenses shall be reimbursed first from the unused portion of the Participant's Pay Conversion Contributions applied to the Health Care Expense Account from the immediately preceding Plan Year and second from the Participant's Pay Conversion Contributions that the Participant has elected to apply to the Health Care Expense Account for the current Plan year.

For purposes of this Section 6.10, Grace Period shall mean the 2 month and 15 day period after the end of the immediately preceding Plan Year. With respect to reimbursements for Health Care expenses incurred during a Grace Period, a request for reimbursement must be received on or before 90 days following the end of the Grace Period.

ARTICLE 7. DEPENDENT CARE ASSISTANCE PLAN

7.1 Dependent Care Assistance Account. The Committee shall establish for each Participant who elects the benefit option under this Article 7, a Dependent Care Assistance Account for each Plan Year. Each Dependent Care Assistance Account shall contain zero dollars ($0.00) initially and at the commencement of each Plan Year.

7.2 Increases in Dependent Care Assistance Account. A Participant's Dependent Care Assistance Account for a Plan Year shall be increased each payroll period by the portion of the Participant's Pay Conversion Contributions for that Plan Year that he has elected to apply toward his Dependent Care Assistance Account in accordance with Section 4.2.

7.3 Decreases in Dependent Care Assistance Account. The balance in a Participant's Dependent Care Assistance Account for a Plan Year shall be reduced by the amount of any benefit paid to or on behalf of a Participant under Section 7.4.

7.4 Dependent Care Benefits. Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 7 and incurs Employment-Related Dependent Care Expenses during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount contained in the Participant's Dependent Care Assistance Account for that

Plan Year. However, no reimbursement shall be paid pursuant to this Article to the extent that an expense has been submitted for reimbursement from a Participant's Health Care Expense Account.

7.5 Reimbursement Procedures. In order to receive reimbursement for dependent care expenses under this Article 7:

(a) The Participant must complete a Claim Form, attach a statement of service from the dependent care provider or other proof of claim, as may be required or permitted pursuant to regulations issued by the U.S. Treasury Department, and forwards the documents to the Administrator. The Participant must provide additional information reasonably requested by the Administrator.

(b) A request for reimbursement that exceeds the balance in the Participant's Dependent Care Assistance Account shall be processed only to the extent of the amount of the account balance. The excess shall be carried over to the following reimbursement period and processed at that time. However, after the Participant's Dependent Care Assistance Account has been exhausted, claims remaining unpaid at the end of the Plan Year shall be canceled. In no event may these claims be resubmitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) A request for reimbursement must relate to Employment-Related Dependent Care Expenses incurred during the Participant's Period of Coverage. For this purpose, the term "incurred" refers to when the dependent care services were provided.

(d) A request for reimbursement for Dependent Care Expenses incurred during a Plan Year must be received by the Administrator either during the Period of Coverage or on or before **90** days following the Period of Coverage.

(e) Reimbursement, if made, shall be made by the Administrator directly to the Participant, which shall cause the Employer, the Plan, and the Administrator to be relieved of all further responsibility with respect to the expense reimbursed.

(f) The Employer may establish a minimum reimbursement amount.

7.6 Separate Written Plan. For purposes of the Code, this Article shall constitute a separate written plan providing a program for the reimbursement of dependent care assistance expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 7.

ARTICLE 8. FORFEITURES AND LIMITATIONS

8.1 Account Forfeitures. Any amounts contributed to a Participant's Health Care Expense Account or Dependent Care Assistance Account which have not been used to pay claims for

benefits incurred by the end of each period of coverage after the period for filing claims has expired shall be forfeited by a participant. Net forfeitures shall be paid to the "flexible benefit plan reserve savings account" pursuant to Section 3.08.040 of the Metropolitan Code.

8.2 Limitation on Contributions and Benefits for Certain Participants. The Committee shall determine, before or during any Plan Year, whether the Plan fails to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Employees who are considered Highly Compensated Employees, under applicable Code provisions. The Committee shall take action that it deems appropriate, under rules uniformly applied to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, with or without the consent of such Employees.

ARTICLE 9. CLAIMS REVIEW PROCEDURES

9.1 Determinations. The Committee shall notify a Participant in writing within 30 days of his written application for benefits of his eligibility or non-eligibility for benefits under the Plan unless special circumstances require an extension of time for perfecting the claim. Notice must be given to the claimant of the extension within 30 days of his submission of the claim. The notice must specify the reason for the extension of the date with which a decision is expected to be rendered.

9.2 Notice. If the Committee determines that a Participant is not eligible for all or part of the benefits, the notice shall set forth (a) the specific reasons for such denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a description of any additional information or material necessary for the claimant to perfect his claim and a description of why it is needed, and (d) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken in the event the participant wishes to submit the denied claim for review.

9.3 Review. If a Participant is determined by the Committee to be ineligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, he shall have the opportunity to have his denied claim reviewed by the Committee by filing a petition for review with the Committee within 60 days after he received the claim denial notice. The petition shall state the specific reasons, which the Participant believes, entitle him to benefits or to greater or different benefits. Within 60 days after the Committee receives the petition for review, the Committee shall afford the Participant (and his counsel, if any) an opportunity to present his position to the Committee orally or in writing, and the Participant (or his counsel) shall have the right to review the pertinent documents.

9.4 Decision. The Committee shall notify the Participant of its final decision in writing within the 60-day period after receiving the request for review stating specifically in writing the basis of the decision in a manner calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based. If, due to special circumstances (such as the need for a hearing), the 60-day period is not sufficient, the final decision may be deferred for

up to another 60-day period at the election of the Committee and notice of this deferral shall be given to the Participant prior to the commencement of the extension. If a Participant dies, the same procedure shall apply to his beneficiaries.

ARTICLE 10. ADMINISTRATION AND FINANCES

10.1 Administration. The Plan shall be administered by the Committee referred to in Section 2.1.

10.2 Powers of Committee. The Committee shall act by a majority of its then Members and shall have the following powers, rights and duties in addition to those vested in it elsewhere in the Plan:

(a) To adopt rules of procedure and regulations it determines may be necessary for the proper and efficient administration of the Plan, consistent with the provisions of the Plan.

(b) To enforce the Plan in accordance with its terms and with rules and regulations adopted by the Committee.

(c) To determine all questions arising under the Plan, including claims for benefits, interpret the Plan, and to remedy ambiguities, inconsistencies or omissions.

(d) To maintain adequate records concerning the Plan and its administration.

(e) To furnish the Employer with such information with respect to the Plan as they may require for tax or other purposes.

A written statement by a majority of Members or by an authorized Member that the Committee has taken or authorized any action shall be conclusive in favor of the person relying on the statement.

10.3 Delegation by the Committee. The Committee may employ agents and counsel (subject to applicable law including the Metropolitan Charter) and delegate to them such powers as the Committee deems desirable. Any such delegations shall be in writing and shall reflect the unanimous action of the Members then acting. The delegation shall describe the advice to be rendered or the functions and duties to be performed by the delegate.

10.4 Uniform Rules. The Committee shall uniformly apply rules and regulations adopted by it to all persons similarly situated.

10.5 Information to be furnished to Committee. The Employer shall furnish the Committee such information as may be required by the Committee. The records of the Employer as to an Employee's or Participant's period of employment, termination of employment and compensation will be conclusive on all persons unless determined by the Committee to be

incorrect. Participants and other persons entitled to benefits under the Plan shall furnish to the Committee such evidence or information as it considers desirable to carry out the Plan.

10.6 Committee Decisions Final. To the extent permitted by law, any interpretation of the Plan and any decision on any matter within the discretion of the Committee made by it in good faith are binding on all persons and shall not be overturned unless such decisions are determined by a court of competent jurisdiction to be arbitrary and capricious. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Committee shall make such adjustment on account thereof as it considers equitable and practicable.

10.7 Compensation. No compensation shall be paid to any Member as such.

10.8 Finances. The costs of the Plan shall be paid from the "flexible benefit plan reserve savings account" pursuant to § 3.08.040(F) of the Metropolitan Code of Laws.

ARTICLE 11. AMENDMENTS AND TERMINATION

11.1 Amendments. The Employer may amend the Plan, in full or in part, at any time. Any amendment shall be timely filed with the Plan documents and reasonable notification provided to Employees.

11.2 Benefits Provided Through Third Parties. In the case of any benefit provided pursuant to any insurance policy or other contract with a third party, the Employer may amend the Plan by changing insurers, policies or contracts without changing the language of this Plan document, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are reasonably informed (to the extent required by law) as to the effects of any such changes. If there is any perceived conflict or inconsistency at any given point in time among the description of benefits contained in the contract or policy and the other Plan documents, the terms of the contract or policy shall control.

11.3 Termination. The Employer intends the Plan to be permanent, but necessarily must, and does, reserve the right to terminate the Plan at any time. In the event of a Plan termination, Pay Conversion Contributions will cease. Thereafter neither the Employer nor any of its Employees shall have any further financial obligations under the Plan except such that have accrued up to the date of termination and have not been satisfied.

ARTICLE 12. MISCELLANEOUS

12.1 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

12.2 Limitation on Liability. The Employer does not guarantee benefits payable under any insurance policy or other similar contracts described or referred to in the Plan, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under the policy or contract.

12.3 Non-Alienation. No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

12.4 Exclusive Benefit. The Plan shall be maintained for the exclusive benefit of Employees. Benefits shall be paid only in accordance with the Plan's terms. Reasonable expenses of administering the Plan may be paid only in accordance with the Plan's terms.

12.5 Applicable Law. The Plan and all rights under the Plan shall be governed by and construed according to the laws of the State of **Tennessee,** except to the extent preempted by Federal Law.

ARTICLE 13. Military Leaves of Absence

13.1 Election Incident to Commencement of Military Leave. Within a reasonable time after the Employer receives notice from a Participant respecting his or her commencement of a leave of absence to enter the Armed Forces of the United States, or respecting his or her call to active duty, and, if practicable, prior to the commencement of such leave, the Participant may elect to continue coverage under the health benefits described in Section 5.1 and Article 6 in which he or she is then participating during the period of such leave. Such Participant may also elect to continue such coverage for his or her IRS Tax Qualified Dependents who were covered under such plan or plans on the day immediately preceding the first day of such leave. Such Participant shall be required to pay, in accordance with the method described in Section 4.3(a), the amount of monthly contribution which would be required if he continued to be an active employee, and such Participant may continue such coverage until the earlier of (i) the date he or she returns from such leave or (ii) 24 months from the date the leave commences. A Participant electing to continue coverage under this Section 13.1 may revoke such election at any time during such leave. Failure to pay the required cost in accordance with Section 4.3(a) shall be deemed a revocation of such election.

13.2 Return from Military Leave

(a) In the event that a Participant returns from a military leave (i) during the same Plan Year in which such leave commenced and before the end of the open enrollment period for the next following Plan Year or (ii) during a period in which coverage for health benefits is continuing under Section 13.1, coverage for the Participant and his or her IRS Tax Qualified Dependents, if applicable, under the health plan in which he or she was participating at the time such leave commenced or which was continuing during such leave shall be reinstated effective as of the date such Participant returns from such leave.

(b) A Participant not described in Section 13.2(a) who returns from a military leave at any time after the end of the open enrollment period for the Plan Year following the Plan Year in which such leave commences, but prior to the time his or her reemployment rights under the Uniformed Services Employment and Reemployment Rights Act expire, may elect:

(i) to have his or her coverage and the coverage for his or her IRS Tax Qualified Dependents, if applicable, under the health plan in which he or she was participating at the time such leave commenced reinstated effective as of the date such Participant returns from such leave, or

(ii) to waive coverage under the health plan which would be reinstated in accordance with subsection (i) above and to make a new election on the same basis as a newly hired Employee within 30 days after he or she returns from military leave; except that such coverage, if timely elected, shall be effective as of the date such Participant returns from such leave.

13.3 Qualified Reservist Distributions ("QRD"). The provisions of this Section 13.3 shall apply to any Participant who is a qualified reservist, as described below, who (i) is ordered or called to active duty on or after January 1, 2008 and (ii) any Participant who is a qualified reservist (1) ordered or called to active duty prior to January 1, 2008, (2) whose active duty commenced on or after January 1, 2008 and (3) who was required to make contributions to the Health Care Expense Account in 2008 because of an irrevocable election made in 2007.

(a) A Participant may request a distribution of all or a portion of the balance in his or her Health Care Expense Account if: (1) the Participant is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period and (2) the request for distribution is made during the period beginning with the date of the order or call to active duty and ending on the last day of the Grace Period for the Plan Year in which the order or call to active duty is issued.

(b) A Participant who is, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 1011), is ordered or called to active duty for a period of 180 days or more or for an indefinite period may request a QRD. A participant ordered or called to active duty before June 18, 2008 is eligible for a QRD if the individual's period of active duty continues after June 18, 2008 and meets the duration requirements described in the preceding sentence. Before any amount may be distributed from a Participant's Health Care Expense Account, the Employer must first receive a copy of the order or call to active duty. The Employer may rely on the order or call to determine the period that the Participant has been ordered or called to active duty. If the order or call specifies that the period of active duty is for 180 days or more or is indefinite, the Participant's eligibility is not affected if the actual period of active duty is less than 180 days or is otherwise changed. If the period specified in the order or call is less than 180 days, the Participant is not eligible for a QRD. However, subsequent calls or orders that increase the

Participant's total period of active duty to 180 days or more will qualify the Participant for a QRD.

(c) The amount which may be distributed to a Participant pursuant to a QRD shall be equal to the amount contributed to the Health Care Expense Account as of the date of the QRD request minus Health Care Expense Account reimbursements received as of the date of the QRD request. A QRD may only be made with respect to a Participant's Health Care Expense Account balance in existence on or after June 18, 2008. A QRD may not be made with respect to amounts (1) forfeited on or before June 18, 2008, (2) attributable to a prior Plan Year (including a plan year ending before June 18, 2008), or (3) attributable to the Dependent Care Assistance Account. A Participant may submit and be reimbursed for claims for medical expenses incurred before the date a QRD is requested.

(d) Distributions shall be made within a reasonable time, but not more than sixty days after the request for a QRD has been made. A QRD may not be made with respect to a Plan Year ending before the order or call to active duty. In addition, except as provided in Section 13.3, a QRD may only be made on or after January 1, 2009.

IN WITNESS WHEREOF, the Employer has caused this amended and restated Plan to be executed on this

21st day of April, 2015.

Metropolitan Government of Nashville & Davidson County
Nashville, TN

By: Edna J. Jones
(signature)

Name: Edna J Jones

Title: Chairman

Date: 4-21-15