TOOLKITS

Understanding Section 125 Cafeteria Plans

April 22, 2021

Overview

A cafeteria plan, also known as a section 125 plan, is a written plan that offers employees a choice between receiving their compensation in cash or as part of an employee benefit. If taken as a benefit, the employee generally receives two tax advantages:

1. Employee contributions toward cafeteria-plan benefits are made pre-tax.
2. Employer contributions toward an employee's cafeteria-plan benefits are not taxed.

The tax savings for employees through the use of pretax dollars to pay for benefits can be substantial. For example, an employee who spends $200 a month in pretax dollars for benefits can, in effect, save $60, assuming about 30 percent of the $200 would have gone to federal, state and local income taxes and FICA (Federal Insurance Contributions Act), the taxes deducted for Social Security and Medicare.

The employer also saves on taxes: For each $200 a month that an employee sets aside, the employer saves about $15—the 7.65 percent of the employee's wages that the employer would otherwise pay for Social Security and Medicare. However, the employer's tax savings may be largely offset by the costs of implementing and maintaining a pretax cafeteria plan.

Any employer with employees who are subject to U.S. income taxes is eligible to sponsor a cafeteria plan. Employers can be C corporations, S corporations, LLCs, partnerships, governmental entities or sole proprietorships. However, nonemployees cannot participate in a cafeteria plan; this exclusion applies to partners in a partnership, members of an LLC and individuals who own more than 2 percent of an S corporation.

To establish a valid cafeteria plan, employers generally must:

- Adopt a written plan document that governs plan administration.
- Make employee plan elections irrevocable, unless revocation is permitted by law.
- Satisfy certain nondiscrimination requirements related to the benefits and contributions provided.

Types of Cafeteria Plans

- **Full flex plans**, in which employers make contributions for all plan-eligible employees, and employees use those contributions to buy various benefits. Employees can then make pre-tax contributions toward any benefit that the employer contributions do not fully cover.
- **Premium-only plans (POPs)**, which allow employees to choose between receiving their full salary in cash or using a share of that salary to pay group insurance policy premiums on a pretax basis.
- **Simple cafeteria plans**, which generally provide employers with 100 or fewer employees a safe harbor from certain plan nondiscrimination requirements in exchange for contributing to each eligible employee's benefits.
- **Flexible spending arrangements (FSAs)**, which allow employees to make contributions toward health care and dependent care expenses on a pretax basis.

Common Benefits Offered

- Group health insurance.
- 401(k) retirement plans.
- Health savings accounts.
- Health flexible spending arrangements.
- Dependent care flexible spending arrangements.
- Group term life insurance.
- Group dental insurance.
- Group vision insurance.
- Group disability insurance.

For a full list of benefits, see IRS Publication 15-B (https://www.irs.gov/forms-pubs/about-publication-15b).

Required Documentation

Several required documents are designed to ensure that a cafeteria plan is compliant with laws and regulations. Such documents include a master plan document and an adoption agreement (sometimes combined into one document) that detail the legal and employer-specific aspects of the employer's benefits plan, including the benefits that are offered, who is eligible to participate, the manner of contributions and other legal notices.

Most employee benefit plans are covered by the Employee Retirement Income Security Act (ERISA) (https://www.dol.gov/general/topic/health-plans/erisa) and must also furnish a summary plan description (SPD). An SPD is a plain-English version of the master plan document and the adoption agreement, and it is meant to inform employees about the aspects of the flexible benefits plan. The SPD must be provided to all eligible employees. The plan documents must be updated and amended at least every five year to reflect any applicable plan changes or regulatory updates.

An insurance policy, coverage certificate or plan booklet received from the insurance carrier or third-party administrator will generally not satisfy the SPD or plan document requirement. While these documents often include detailed descriptions of the benefits available under the plan, they rarely include all required information, such as a named fiduciary or the procedures for amending the plan. One simple and cost-effective solution is the wrap document, a relatively simple document that "wraps around", or incorporates, the insurance policy, coverage certificate or plan booklet. The benefits available under the plan continue to be governed by the insurance policy, coverage certificate or plan booklet, while the wrap document supplements it with the information necessary to comply with ERISA. In effect, the wrap document fills the gaps left by insurance carriers and third-party administrators. *See* What is the difference between a plan document and a summary plan description? (www.shrm.org/ResourcesAndTools/tools-and-samples/hr-qa/Pages/whatsthediffbetweenplandocsandasummaryplandescription.aspx)

Employers must ensure that the rules outlined in the plan document and SPD are followed. Failure to administer a plan in accordance with the written terms of the plan and the Internal Revenue Code can result in the loss of the benefits' pretax status.

Employers that utilize a third-party administrator (TPA) must maintain written medical privacy policies and procedures as required under the Health Insurance Portability and Accountability Act (HIPAA) and have a signed business associate agreement with the TPA. Medical privacy policies and procedures detail how and when an employer can use and disclose protected health information, and the business associate agreement details how and when the TPA can use or disclose protected health information. The TPA should be able to provide the necessary documentation for the plan documents, the medical privacy policies and procedures, and the business associate agreement. *See* Summary of the HIPAA Privacy Rule (https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html) and Business Associate Contracts (http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html).

Feedback

Election Changes

Editor's Note: Internal Revenue Service (IRS) notices 2020-29 (https://www.irs.gov/pub/irs-drop/n-20-29.pdf), 2020-33 (https://www.irs.gov/pub/irs-drop/n-20-33.pdf), and 2021-15 (https://www.irs.gov/pub/irs-drop/n-21-15.pdf) provide for increased flexibility with respect to mid-year elections, carryovers and grace periods under a section 125 cafeteria plan during calendar year 2020 and 2021 due to COVID-19. The notices apply to employer sponsored health coverage, health flexible spending arrangements (health FSAs), health savings accounts (HSAs,) individual coverage health reimbursement arrangements (ICHRAs) and dependent care assistance programs (DCAPs).

Employees' cafeteria-plan elections are generally irrevocable until the beginning of the next plan year. However, a cafeteria plan may generally permit an employee to revoke an election and make a new one midyear due to any one of the following:

- Change-in-status events, such as a change in marital status, number of dependents, residency or employment status.
- Significant cost or coverage changes.
- Special enrollment entitlement.
- FMLA leave.
- Medicare entitlement.

CHANGE-IN-STATUS EVENTS

The following life events can trigger a change-in-status event:

- A change in an employee's marital status, including marriage, divorce, legal separation or annulment.
- An increase or decrease in the number of dependents, including the birth of a child, the death of a dependent, adoption and placement for adoption
- A change in the employment status of the employee, employee's spouse, or employee's dependents, including the termination or commencement of employment, a commencement of or a return from an unpaid leave of absence, or a change in worksite.
- An employee's dependent satisfies or ceases to satisfy eligibility requirements for coverage due to attainment of age, a change in student status or any similar circumstance.
- A change in the place of residence of the employee, spouse or dependent.
- A participating employee's reduction in work hours so that the employee is expected to average less than 30 hours of service per week.
- A participating employee's becoming eligible for open or special enrollment in a plan offered through a health insurance marketplace.

The requested election change must be consistent with the change-in-status event. For example, if an employee gets divorced, the employee's election under the cafeteria plan to cancel health coverage for any individual other than his or her spouse involved in the divorce would fail to correspond with that change-in-status event.

SIGNIFICANT COST OR COVERAGE CHANGES

A cafeteria plan may permit an employee to change his or her election during a plan year if one of the following occurs:

- The cost charged to an employee for a benefit significantly increases or decreases, including when the employee or his or her spouse or dependents become eligible for COBRA coverage.
- A benefit is significantly curtailed, including curtailments that result in a loss of coverage or an increase in deductible, co-pay or out-of-pocket amounts.
- A benefit option is added or improved.

SPECIAL ENROLLMENT ENTITLEMENT

HIPAA allows employees and their spouses and dependents who initially declined group health insurance coverage during open enrollment to nonetheless participate in the group plan when certain circumstances occur. This is referred to as "special enrollment." When this happens, a cafeteria plan may allow the employees (and their spouses and dependents) to change their cafeteria-plan elections.

The following events trigger HIPAA special enrollment rights:

- Loss of eligibility for other group health coverage.
- Termination of employer contributions toward other group health coverage.

- Certain life events, including marriage, birth, adoption, or placement for adoption.
- Loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid.
- Determination of eligibility for premium assistance under CHIP or Medicaid.

FMLA LEAVE

An employee taking leave under the federal Family and Medical Leave Act (FMLA) may be permitted to revoke an existing election of group health plan coverage during his or her FMLA leave period.

MEDICARE ENTITLEMENT

If an employee, spouse or dependent enrolled in a group health plan benefit becomes entitled to coverage under Medicare, a cafeteria plan may permit the employee to make an election change to cancel or reduce the coverage of that employee, spouse or dependent.

Additional exceptions may apply. For more information, contact the Internal Revenue Service (https://www.irs.gov/)at 1-800-829-4933.

Nondiscrimination Rules

Cafeteria plans are generally subject to the nondiscrimination requirements of Internal Revenue Code section 125 (https://www.law.cornell.edu/uscode/text/26/125). To satisfy the section 125 nondiscrimination requirements, a plan generally must fulfill the following three tests:

- **Eligibility Test:** The plan may not discriminate in favor of highly compensated individuals as to eligibility to participate.
- **Benefits and Contributions Test:** The plan may not discriminate in favor of highly compensated participants as to benefits and contributions.
- **Key Employee Concentration Test:** The nontaxable benefits provided to key employees may not exceed 25 percent of the nontaxable benefits provided for all employees under the cafeteria plan.

If a plan fails any of these nondiscrimination tests, the highly compensated participant or key employee participating in the plan will lose the favorable tax treatment of the cafeteria-plan benefit and must include in his or her gross income the value of the taxable benefit with the greatest value that the employee could have elected to receive. Participants who are not highly compensated or key employees will not lose their tax benefits and are not impacted by the failure of a plan to pass nondiscrimination testing.

Safe Harbors

Safe harbors for satisfying these nondiscrimination tests exist for simple cafeteria plans POPs meeting specific requirements. For more information on the safe harbor for POPs, see the 2007 proposed cafeteria plan regulations (https://www.gpo.gov/fdsys/pkg/FR-2007-08-06/pdf/E7-14827.pdf), which employers may rely on for guidance pending the issuance of final regulations.

HIGHLY COMPENSATED INDIVIDUALS

For purposes of section 125, the term "highly compensated individual" means an individual who is:

- An officer of the company.
- A shareholder owning more than 5 percent of the voting power or value of all classes of the employer's stock.
- Highly compensated (generally $130,000 in compensation and, if elected by the employer, in the top-paid 20 percent of employees).
- A spouse or dependent of an individual described in the three bullet points above.

HIGHLY COMPENSATED PARTICIPANTS

For purposes of section 125, the term "highly compensated participant" means a highly compensated individual (see above) who is eligible to participate in the cafeteria plan.

KEY EMPLOYEES

For purposes of section 125, a key employee is generally an employee who is either of the following:

- An officer of the company having annual pay of more than $185,000.
- An employee who is either of the following:
  - A 5 percent owner of the business.
  - A 1 percent owner of the business whose annual pay is more than $150,000.

Due to the complexity of testing plans for compliance with the section 125 nondiscrimination rules, any employer that is considering offering health benefits to only certain classes of employees should seek the advice of a knowledgeable benefits attorney.

Simple Cafeteria Plans

Federal law allows certain small employers to establish so-called simple cafeteria plans that are automatically treated as satisfying the Internal Revenue Code's nondiscrimination requirements for cafeteria plans. To offer a simple cafeteria plan, an employer generally must satisfy three requirements:

1. Employer size requirements.
2. Employer contribution requirements.
3. Employee participation requirements.

EMPLOYER SIZE REQUIREMENTS

Employers are generally eligible to establish a simple cafeteria plan if they employ an average of 100 or fewer employees during either of the two preceding years. However, if the business was not in existence throughout the preceding year, employers are eligible to establish a simple cafeteria plan if they reasonably expect to employ an average of 100 or fewer employees in the current year. In addition, if the employer establishes a simple cafeteria plan in a year that they employ an average of 100 or fewer employees, they are considered an eligible employer for any subsequent year as long as they do not employ an average of 200 or more employees in a subsequent year.

EMPLOYER CONTRIBUTION REQUIREMENTS

Employers must contribute toward the benefits of each plan-eligible employee in an amount equal to one of the following:

- A uniform percentage—not less than 2 percent—of the employee's compensation for the plan year.
- An amount that is at least 6 percent of the employee's compensation for the plan year, or twice the amount the employee contributes toward his or her cafeteria-plan benefits, whichever is less.

If the contribution requirements are met using the second option above, the employer's rate of contribution to any highly compensated individual or key employee cannot be greater than its rate of contribution to any other individual or employee.

EMPLOYEE PARTICIPATION REQUIREMENTS

In general, employers must allow all employees who had at least 1,000 hours of service in the preceding plan year to participate in a simple cafeteria plan. However, employers may exclude from the plan employees who meet one of the following criteria:

- Are under age 21 before the close of a plan year.
- Have less than one year of service with the employer as of any day during the plan year.

In addition, each eligible employee must be able to elect any benefit available under the plan unless he or she is subject to a limitation that is applicable to all plan participants.

Additional requirements and exceptions may apply. For more on simple cafeteria plans, see IRS Publication 15-B (https://www.irs.gov/publications/p15b).

City of Johnson City

Section 125 Premium Only Plan (POP)
Plan Document

Effective as of October 1, 2021

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City of Johnson City

Section 125 Premium Only Plan (POP)

ARTICLE I

Introduction

1.1 Purpose of Plan. The purpose of this Plan is to provide eligible employees of City of Johnson City a choice between cash and benefits under one or more Qualified Benefit Plans.

1.2 Plan Status and Establishment. This Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code of 1986, as amended from time to time (the "Code"). The Plan was established effective October 1, 2021.

ARTICLE II

Participation

2.1 Commencement of Participation. Each Employee will be eligible to participate in the Plan on the first day on which he or she meets the eligibility requirements of any Qualified Benefit Plan. An Employee will become a Participant upon making an election in accordance with the provisions of Section 3.3.

2.2 Cessation of Participation. A Participant will cease to be a Participant in this Plan as of the earlier of (i) the date on which this Plan terminates or (ii) the date on which he or she dies, terminates employment with the Plan Sponsor, or ceases to be an Employee eligible to participate under Section 2.1.

2.3 Reinstatement of Former Participant. A former Participant will again become a Participant if and when he or she first meets the eligibility requirements of Section 2.1.

2.4 Participation During Uniformed Services Leave of Absence; Similar State Leaves. Any Employee who is absent from work due to a period of duty in the Uniformed Services; or leave under a similar or equivalent, applicable state family and medical leave law that requires health benefits continuation, will have the right to continue participation in any Qualified Benefit Plan. The Employee's right to maintain coverage while on a leave of absence is conditioned on the Employee's continuing to have an employment relationship with the Plan Sponsor and making the required contributions as provided in Section 3.9, as applicable.

ARTICLE III

Optional Benefits

3.1 Contributions. A Participant may elect under this Plan to receive his or her full Compensation for any Plan Year in cash or to have a portion of his or her Compensation applied by the Plan Sponsor to the payment of Employee Provided Premiums, as the case may be, under any one or more Qualified Benefit Plan(s).

3.2 Receipt of Benefits other than Cash. While the election to receive benefits under one or more Qualified Benefit Plans in lieu of cash is made under this Plan, benefits will be provided under the applicable Qualified Benefit Plan. The options available under each such plan, the requirements for participating in such options, the amount of premiums, deductibles and co-payments (if any), the amount, timing and conditions for the receipt of benefits and all other terms and conditions of eligibility, coverage and benefits under such options are set forth in the Qualified Benefit Plans. Any claim which arises under a Qualified Benefit Plan will be subject to review under the Qualified Benefit Plan and not under this Plan.

3.3 Election of Benefits. Once a Participant enrolls in any one or more of the Qualified Benefit Plans, he or she will be deemed to have elected to have his or her Compensation reduced to the extent necessary to satisfy the Participant's Employee Provided Premiums due under such Qualified Benefit Plans, unless by written notice (on forms provided by the Plan Sponsor) to the Administrator prior to the start of any coverage period, a Participant elects not to have any Compensation reductions contributed to the Employee Provided Premiums under one or more Qualified Benefit Plans.

3.4 Irrevocability of Election by the Participant.

(a) Any election made under the Plan shall be irrevocable by the Participant during the Plan Year except as otherwise provided in (b) through (l) below.

(b) With respect to any Qualified Benefit Plan, a Participant may revoke an election in writing for the balance of the Plan Year and, if desired, file a new election in writing if, under the facts and circumstances, (i) a change in status occurs, and (ii) the requested revocation and new election satisfy the consistency requirements in Section 3.5 below. For this purpose, a change in status includes the following events:

(i) Legal Marital Status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.

(ii) Number of Dependents. An event that changes a Participant's number of Dependents who may be eligible for coverage under a Qualified Benefit Plan, including birth, death, adoption or placement for adoption.

(iii) Employment Status. An event that changes the employment status of the Participant or the Participant's spouse or Dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his or her employer.

(iv) Requirements for Unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(v) Residence. A change in the place of residence of the Participant, his or her spouse or Dependent.

(vi) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a group health plan that is a Qualified Benefit Plan, a Participant may revoke an election in writing for the balance of the Plan Year and file a new election in writing that corresponds with the special enrollment rights provided in Code Section 9801(f), whether or not the change in election is permitted under Section 3.4(b).

(d) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election (i) in order to provide coverage for the child under a group health plan that is a Qualified Benefit Plan if the order so requires, or (ii) in order to cancel health coverage under a group health plan that is a Qualified Benefit Plan for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of coverage under a group health plan that is a Qualified Benefit Plan, a Participant may revoke an election for the balance of the Plan Year and file a new election in order to cancel or reduce such medical coverage for the Participant or any covered Dependent of the Participant to the extent that the Participant or Dependent becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Plan Year to commence or increase coverage under another group health plan that is a Qualified Benefit Plan.

(f) If the Participants' share of the cost of coverage under a Qualified Benefit Plan significantly increases or significantly decreases during the Plan Year, a Participant may make a corresponding change in election under the Plan for the balance of the Plan Year, which will include (but not be limited to) the following:

(i) for a significant cost increase, Participants electing such coverage for the Plan Year may revoke their election and either elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan; or

(ii) for a significant cost decrease, Participants may elect to commence participation under certain options under a Qualified Benefit Plan with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

Despite any other contrary provision of the Plan, for any insignificant changes in the costs of any Qualified Benefit Plans, the Administrator shall automatically change Participants' elections to account for such changes in cost.

(g) If the Participant or his or her spouse or Dependents experience a significant curtailment in coverage under a Qualified Benefit Plan during the Plan Year, the Participant may make a corresponding change in election under the Plan for the balance of the Plan Year as follows:

(i) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year; or

(ii) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and either elect similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan.

(h) If during the Plan Year a new Qualified Benefit Plan, or option under a Qualified Benefit Plan, becomes available, or an existing Qualified Benefit Plan, or option under a Qualified Benefit Plan, is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

(i) If a Participant's spouse or Dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with the election change made by the Participant's spouse or Dependent, if:

(i) the election change made by the Participant's spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code Section 125; or

(ii) the period of coverage under the plan maintained by the employer of the Participant's spouse or Dependent does not correspond with the Plan Year of this Plan.

(j) If a Participant or his or her spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect health coverage under one or more Qualified Benefit Plan(s) for the balance of the Plan Year for the Participant, his or her spouse or Dependent.

(k) If a Participant enrolls in or intends to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit the Participant to revoke an election under the Plan that is on account of and corresponds with the Participant's (and any related individuals who cease coverage due to the revocation) enrollment in a Marketplace plan effective immediately following the revocation. The Administrator may rely on the reasonable representation a Participant who is enrolling in Marketplace coverage that the Participant and related individuals have enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation. No change is permitted with regard to non-health benefits available under the Plan.

(l) If a Participant who was reasonably expected to average 30 hours of service or more per week 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 under the Plan, provided that the Participant certifies to the Administrator 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" (as defined under the Affordable Care Act) for coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked. No change is permitted with regard to non-health benefits available under the Plan.

(m) Any application for a revocation and new election under this Section 3.4 must be made within 30 days following the date of the actual event, or within 60 days of the occurrence of one of the following events: (i) a Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or (ii) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan, and shall be effective at such time as the

Administrator shall prescribe.

3.5 Consistency Rules. A Participant's requested revocation and new election under Section 3.4(b) will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Qualified Benefit Plan or under a plan maintained by the employer of the Participant's spouse or Dependent. A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the plan.

3.6 Automatic Termination of Election. Elections made or deemed to be made under Section 3.3 will automatically terminate on the date on which the Participant (i) terminates employment with the Plan Sponsor or (ii) elects under Section 3.3 or 3.4 to receive cash in lieu of benefits under the Qualified Benefit Plans, although coverage or benefits under any group health plan that is a Qualified Benefit Plan may continue if and to the extent provided by such plan or as required by law. Despite any other contrary provision of the Plan, if a Participant's employment with the Plan Sponsor terminates and the Participant returns to employment with the Plan Sponsor within thirty (30) days of such termination and within the same Plan Year of the Participant's date of termination, then the Participant's pre-termination elections under the Plan will be automatically reinstated, and no election changes shall be permitted unless otherwise specified by Section 3.4.

3.7 Changes by Administrator. If the Administrator determines, at any time, that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Code with respect to benefits provided to highly compensated individuals (as defined in Code Section 105(h)), highly compensated employees (as defined in Code Section 414(q)) or key employees (as defined in Code Section 416(i)(1)), the Administrator will take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements. Such action may include, without limitation, a modification of elections by such highly compensated individuals, highly compensated employees or key employees with or without their consent.

3.8 Maximum Contributions. The maximum amount of the contributions under this Plan for any Participant in any Plan Year will be the sum of the Employee Provided Premiums, as amended from time to time, of the most expensive benefits available to the Participant under each Qualified Benefit Plan for such Plan Year.

3.9 Premium Payments by Employees of Uniformed Services Leave of Absence; Similar State Leaves. Any Employee who elects to maintain coverage under Section 2.4 while absent from work for more than 31 days for duty in the Uniformed Services must continue to make any required contributions specified in Section 3.3. During such absence, an Employee may choose to make such contributions by (i) remitting payment to the Plan Sponsor on or before each pay period for which the contributions would have been deducted from the Employee's paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date, or (ii) at the Employee's written election (on forms furnished by and delivered to the Administrator not less than 30 days prior to prepayment), prepaying the amounts that will become due during such leave out of one or more of the Employee's paychecks preceding such leave. The Plan Sponsor, in its sole discretion, may agree with the Employee to fund the Employee's required contributions under Section 3.3 during the leave of absence, as long as the Employee agrees (on forms furnished by and delivered to the Administrator not less than 30 days prior to commencement of such leave of absence) to commence remitting payment to the Plan Sponsor upon the Employee's return to active employment with the Plan Sponsor following the leave of absence of all amounts paid by the Plan Sponsor on the Employee's behalf to maintain coverage under Section 2.4; provided, however, if an Employee fails to return to active employment with the Plan Sponsor following the leave of absence, then the Employee shall reimburse the Plan Sponsor for such advances made on the Employee's behalf within thirty (30) days following the Plan Sponsor's written demand for such reimbursement. Despite the foregoing, an Employee who is absent from work for any paid leave of absence must continue any and all benefits elected under this Plan (unless the same is prohibited by any insurance policy provision requiring an insured to be actively at work), and Employee contributions for those benefits that the Employee chooses to continue while on the leave of absence will continue to be deducted from the Employee's paycheck in such absence.

ARTICLE IV

Administration

4.1 Plan Administration. The administration of the Plan will be under the supervision of the Administrator. It will be a duty of the Administrator to ensure that the Plan is carried out, in accordance with its terms and in a nondiscriminatory manner, for the exclusive benefit of Participants and their beneficiaries. The Administrator will have the power to

administer the Plan, subject to applicable requirements of law. The Administrator's powers include, but are not limited to, discretionary authority:

(a) to make and enforce such rules and regulations as the Administrator deems necessary or appropriate for the efficient administration of the Plan;

(b) to interpret the Plan (such interpretation will be final, binding and conclusive with respect to all claims arising under this Plan);

(c) to decide all questions concerning the eligibility of any person to participate in and to receive benefits under the Plan, and to make all factual determinations;

(d) to provide Employees with a reasonable and timely notification of benefit options available under the Plan;

(e) to authorize the payment of benefits, which will be paid only if the Administrator decides in its sole discretion that the Participant or applicant is entitled to them; and

(f) to appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

4.2 Payment of Expenses. Administrative expenses will be paid by the Plan Sponsor. The Administrator may impose reasonable conditions for payments, provided that such conditions do not discriminate in favor of Participants who are highly compensated employees or key employees.

4.3 Examination of Records. The Administrator will make available to each Participant his or her records under this Plan for examination at reasonable times during normal business hours.

4.4 Reliance on Tables, Etc. In administering the Plan, the Administrator will be entitled to rely conclusively on all tables, valuations, certificates, opinions and reports furnished by, or in accordance with the instructions of, any insurer, or by accountants, counsel or other experts employed or engaged by the Administrator.

4.5 Indemnification of Administrator. The Plan Sponsor agrees to indemnify, hold harmless and defend any Employee serving as the Administrator or as a member of a committee designated as the Administrator (including any Employee or former Employee who previously served as the Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Plan Sponsor) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

4.6 Insurance Contracts Control. Despite any other provision of this Plan, if the terms of this Plan and the terms of an insurance contract which funds a Qualified Benefit Plan (as applicable) conflict, the terms of such insurance contract will control unless contrary to law.

ARTICLE V

Amendment and Termination

5.1 Amendment of Plan. The Plan Sponsor reserves the right to amend this Plan at any time without the consent of any Employee or Participant.

5.2 Termination of Plan. It is the expectation of the Plan Sponsor that it will continue this Plan indefinitely, but the continuance of this Plan is not assumed as a contractual obligation of the Plan Sponsor, and the right is reserved to the Plan Sponsor at any time for any reason to terminate this Plan without liability. Upon termination of the Plan, all elections and reductions in Compensation relating to the Plan will terminate.

5.3 Legal Enforceability of Provisions. The Plan and the provisions hereof constitute a legally enforceable agreement between the Plan Sponsor and a Participant.

ARTICLE VI

Claims Provisions

6.1 Claims Procedure. Claims for underlying benefits under the Qualified Benefit Plan shall be governed by the claims

procedures in the applicable Qualified Benefit Plan, except that claims with respect to eligibility for salary reductions under this Plan (such as the ability to pay for Qualified Benefit Plan coverage on a pre-tax basis) shall be submitted to, and decided by, the Administrator.

ARTICLE VII

Miscellaneous

7.1 Communication to Employees. Promptly after the Plan is made effective, the Plan Sponsor will notify all Employees of its availability and terms. The Plan Sponsor will notify each new Employee of the availability and terms of the Plan as soon as practicable following the date the Employee commences his or her employment with the Plan Sponsor. Within a reasonable period of time prior to the commencement of each Plan Year, or, in the case of a newly eligible Employee, as soon as practicable following the date on which he or she commences his or her employment with the Plan Sponsor, the Plan Sponsor will provide to Employees booklets, brochures, or other explanatory items which describe the material provisions of the Plan (to the extent the same have not been previously furnished).

7.2 Participant's Rights. This Plan will not be deemed to constitute an employment contract between the Plan Sponsor and any Participant or to be in consideration of or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will be deemed to give any Participant or Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant in this Plan.

7.3 Protective Clauses.

(a) If a Participant fails to obtain coverage under any insured Qualified Benefit Plan (whether as a result of the negligence or gross neglect of the Plan Sponsor or otherwise), such Participant's sole and exclusive remedy will be the return of the amount of the Employee Provided Premiums actually paid by such Participant in the Plan Year(s) for which coverage was not obtained.

(b) If and to the extent payments or reimbursements due under an insured Qualified Benefit Plan are required to be paid to the Plan Sponsor, as agent for a Participant or the spouse, Dependent or other beneficiary of such Participant or otherwise, the Plan Sponsor's liability for any claim brought by a Participant or by the spouse, Dependent or other beneficiary of a Participant with respect to such payment or reimbursements will be limited to the amount of the payments or reimbursements, if any, actually received by the Plan Sponsor thereunder in connection with such claim. If payments or reimbursements under an insured Qualified Benefit Plan are not timely received by the Plan Sponsor following the submission of a claim, the Plan Sponsor will so notify the Participant. Thereafter, the Plan Sponsor will have no obligation to pursue such claim, and the Participant may pursue, settle or compromise such claim as the Participant, in the sole exercise of his or her discretion, sees fit.

(c) The Plan Sponsor will not be responsible for the validity of any insurance contract which funds an insured Qualified Benefit Plan or for the failure of an insurer to make payments provided for thereunder, or for the action of any person which may cause any such insurance contract to be rendered null and void or unenforceable, in whole or in part.

(d) Once coverage under an insured Qualified Benefit Plan is applied for and obtained, the Plan Sponsor will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Plan Sponsor. Where premium notices are timely received by the Plan Sponsor, the Plan Sponsor's liability for the payment of premiums corresponding to such notices will be limited to the dollar amount of such premiums and will not include liability for any other loss which may result from the failure to pay such premiums.

(e) The Plan Sponsor will not be liable for the payment of any premium due under a Qualified Benefit Plan or any loss which may result from the failure to pay such premium if the amounts deferred under Section 3.3 are insufficient to provide for the payment of the Employee Provided Premium of a Qualified Benefit Plan at the time such premium is due. The Plan Sponsor will notify a Participant if such amounts are insufficient to pay such premiums but will not be liable for any failure to make such notification. Such premiums may be paid (i) if permitted under Code Section 125, pursuant to an amendment to a Participant's election under Section 3.3 or (ii) otherwise, by a cash contribution of the Participant.

7.4 No Guarantee of Tax Consequences. Neither the Administrator nor the Plan Sponsor makes any representation or

warranty that any amount paid as premiums or distributed as benefits under any Qualified Benefit Plan will be excludable from the gross income of a Participant for federal or state income tax purposes. It will be the obligation of each Participant to determine whether payments are excludable from the Participant's gross income for federal and state income tax purposes.

7.5 Indemnification of the Plan Sponsor by Participants. If any Participant receives payments or reimbursements which do not qualify for exclusion from gross income, such Participant will indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal or state tax from such payments or reimbursements, provided however that such indemnification and reimbursement will not exceed the amount of additional federal and state tax (together with any interest and penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, less any such additional tax actually paid by the Participant.

7.6 Funding. Unless otherwise required by law, (i) contributions to the Plan will be deemed general assets of the Plan Sponsor until the amount thereof has been paid over to or under a Qualified Benefit Plan and (ii) nothing herein contained will be construed to require the Plan Sponsor or the Administrator to maintain any fund or segregate any amount, in trust or otherwise, for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any asset of the Plan Sponsor from which any payment under the Plan may be made.

7.7 Non-assignability of Rights. The right of any Participant to receive any amount under the Plan will not be alienable by the Participant by assignment or any other method, and will not be subject to the rights of creditors, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

7.8 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under this Plan, will be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor or Administrator, except as provided herein.

7.9 Governing Law. This Plan will be construed, administered and enforced according to the laws of Texas, to the extent not superseded by the provisions of the Code and any other applicable federal law.

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

7.11 Savings Clause. If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

ARTICLE VIII

Definitions

As used herein, unless the context clearly indicates otherwise, the following words and phrases when capitalized have the meanings herein specified. A pronoun or adjective in the masculine gender includes the feminine and neuter genders, and the singular includes the plural, unless the context clearly indicates a different meaning.

8.1 "Administrator" means the Plan Sponsor or such other person or committee as may be appointed from time to time by the Plan Sponsor to supervise the administration of the Plan.

8.2 "Affiliated Employer" means the Plan Sponsor and any corporation, listed on Appendix A, which is: (i) a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Plan Sponsor; (ii) any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Plan Sponsor; or (iii) any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Plan Sponsor; and any other entity required to be aggregated with the Plan Sponsor pursuant to Treasury regulations under Code Section 414(o).

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

8.4 "Compensation" means the total cash remuneration received by a Participant from the Plan Sponsor during a Plan Year prior to any reductions under Section 3.3. Compensation includes overtime, commissions and bonuses.

8.5 "Contract Period" means the 12-month period ending with or within the Plan Year which will be designated by the Administrator for purposes of making or changing benefit elections under this Plan, except as provided in Section 3.3(a) (relating to the election of benefits by a newly eligible Employee).

8.6 "Dependent" means any person who falls within the definition of dependent under Code Section 152, as modified by Code Section 105(b), and any child of a Participant as defined in Code Section 152(f)(1) until the end of the year in which the child attains age 26. Notwithstanding anything in the Plan to the contrary, any pre-tax payments made pursuant to the Plan with respect to a domestic partner and/or the child of a domestic partner who does not qualify as the Employee's Dependent shall be treated as taxable compensation. This taxable compensation shall be treated as wages reportable on the Employee's Form W-2 and shall be subject to income tax and social security tax withholding.

8.7 "Employee" means any individual employed by the Plan Sponsor. However, only those individuals classified as "employees" by the Plan Sponsor shall be eligible to participate, including any leased employees within the meaning of Code Section 414(n)(2). Independent contractors, freelancers and individuals hired through staffing firms shall not be eligible to participate in the Plan even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court. An employee shall not include any self-employed individual, partner in a partnership, and more-than-2% shareholder in a Subchapter S corporation.

8.8 "Employee Provided Premium" means the sum of (i) that portion of the total premium cost of a Qualified Benefit Plan that requires payment of premiums, which is required to be paid by the Employee, either by law or by agreement, and depending on what options exist under such plan (e.g., to the extent applicable, individual or family coverage, high or low deductibles, etc.), as adjusted from time to time to reflect changes, if any, in the percentage of such premiums paid by the Employee and/or changes in the total amount of such premiums, and (ii) a pro rata share of the costs of the administration of the Plan (allocated on a uniform basis) to the extent that the Plan Sponsor determines that such costs will be borne by Participants pursuant to Section 4.2.

8.9 "Participant" means an Employee who participates in the Plan in accordance with Article II.

8.10 "Plan" means the City of Johnson City Section 125 Premium Only Plan (POP) as set forth herein, together with all amendments and restatements.

8.11 "Plan Sponsor" means City of Johnson City and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Plan Sponsor. Notwithstanding the previous sentence when the Plan provides that the Plan Sponsor has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan) the term "Plan Sponsor" shall mean only City of Johnson City. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in Appendix A.

8.12 "Plan Year" means the short plan year beginning October 1, 2021 and ending September 30, 2022. Thereafter, Plan Year is the twelve-month period ending each September 30th.

8.13 "Qualified Benefit Plan" refers to any employer-sponsored welfare benefit plan designated from time to time by the Plan Sponsor, and communicated in writing to Participants, for purposes of providing various benefits under this Plan.

8.14 "Uniformed Services" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated as such by the President of the United States in time of war or emergency.

Executed this ____ day of _____, 2022.

City of Johnson City

By: _____

Name: _____

Title: _____

APPENDIX A

PARTICIPATING EMPLOYERS

As of October 1, 2021

Each entity listed below has sufficient common ownership with the Plan Sponsor so as to constitute a member of a commonly controlled group as described in Code §414(b), (c), (m) or (o) and has adopted the Plan with the consent of the Plan Sponsor.

None

SUMMARY PLAN DESCRIPTION

For

CITY OF JOHNSON CITY SECTION 125 PREMIUM ONLY PLAN (POP)

Effective as of October 1, 2021

Table of Contents

CITY OF JOHNSON CITY SECTION 125 PREMIUM ONLY PLAN (POP)
SUMMARY PLAN DESCRIPTION

INTRODUCTION

We are pleased to announce that we have established a Section 125 Premium Only Plan (POP) (the "Plan") under which you may choose to redirect a portion of your wages, on a pre-tax basis, to pay for your share of the costs of available health and welfare plans that we sponsor. This means that you will pay less in taxes each year.

Read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a participant. You should direct any questions you have to the Plan Administrator. There are Plan documents available upon request for your review.

IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENTS, THE PLAN DOCUMENTS WILL PREVAIL. IF THERE IS A CONFLICT BETWEEN AN INSURANCE CONTRACT WHICH FUNDS BENEFITS AND EITHER THE PLAN DOCUMENTS OR THIS SUMMARY PLAN DESCRIPTION, THE INSURANCE CONTRACT WILL PREVAIL.

I. ELIGIBILITY

1.1 Will I Become Eligible To Participate In This Plan?

You will become eligible to participate in this Plan on the first day on which you enroll in any of the Plan Sponsor's health and welfare plans available under this Plan. You will become a participant upon making an election as described in Section 1.2 below.

For eligibility rules concerning the Plan Sponsor's health and welfare plans, please see the summary plan description or plan document for each. You should ask the Plan Administrator for copies of such documents if you need them.

Please note that if you are initially classified as an independent contractor (or any other non-employee designation) by your Employer and are subsequently determined to be a common law employee for any purpose, including without limitation, for wage, labor or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court, you will still be ineligible for participation in the Plan for the period during which you were a non-employee. An employee shall not include any self-employed individual, partner in a partnership, and more-than-2% shareholder in a Subchapter S corporation.

1.2 What Must I Do To Enroll In The Plan?

If you elect to enroll in any benefit that is included in this plan (as communicated in your enrollment materials), you will be deemed to have elected to enroll in this plan and your compensation will be reduced to make pre-tax contributions for your share of the premiums for any benefits you elect, as applicable. Your participation will continue each Plan Year so long as you remain covered under each applicable benefit as of the last day of the Plan Year for that benefit. You must notify the Plan Sponsor in writing during open enrollment that you no longer intend to participate in any applicable benefit(s) the next Plan Year to cease participating in the Plan.

II. OPERATION

2.1 How Does The Plan Operate?

Your salary or wages will be deducted on a pre-tax basis, and your salary reductions allocated to pay for the cost of the employee portion of the premiums due under any of the health and welfare plans available under the Plan initially upon enrollment (for new employees) and each year thereafter (for current employees).

III. CONTRIBUTIONS

3.1 How Is My Compensation Measured Under The Plan?

Compensation under the Plan means the total cash amount that is paid to you each year.

3.2 What Contributions Are Made To The Plan?

By enrolling in any of the underlying health and welfare benefits, your salary or wages are reduced by a certain amount that represents your share of the cost of such benefits and are contributed to the Plan.

3.3 What Happens To Contributions That Are Made To The Plan?

By your election, contributions that you defer are set aside, only to be used to pay the cost of the employee portion of applicable premiums in your employer-sponsored health and welfare plans in which you are enrolled.

3.4 When Must I Decide What Coverage I Want?

Except as described in Section 3.6 below, you may elect benefits under the Plan only during the "election period."

3.5 When Is The Election Period For The Plan?

You will be provided an opportunity to elect any underlying health and welfare benefits in accordance with the terms of the plans for those benefits. However, once you are enrolled in those benefits, you will be deemed to have elected to enroll in this plan and your compensation will be reduced to make pre-tax contributions for your share of the premiums for any benefits you elect, as described above in Section 1.2.

3.6 May I Change My Elections During The Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change certain elections if you experience an IRS defined "change in status" and/or other special events as described below.

Examples of status changes include these events:

(i) marriage;

(ii) divorce, legal separation or annulment;

(iii) death of your spouse or dependent child;

(iv) birth, adoption or placement for adoption of a child;

(v) termination of the employment of your spouse or dependent child;

(vi) commencement of the employment of your spouse or dependent child;

(vii) your or your spouse's or dependent child's commencement or return from an unpaid leave of absence from employment;

(viii) adjustment to your or your spouse's or dependent child's work schedule, such as a switch between part-time and full-time work, a strike, a lockout or an increase or reduction in hours of employment, that causes a loss of coverage;

(ix) a change in your or your spouse's or dependent child's worksite or residence that causes a loss of current coverage eligibility;

(x) adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the Plan;

(xi) significant change in your or your spouse's health coverage attributable to the spouse's employment; and

(xii) leave of absence under the Family Medical and Leave Act.

Your election may also be changed if one of these special events occurs:

(i) the issuance of a judgment, decree or order that requires accident or health coverage for your dependent child.

(ii) your or your spouse's or dependent child's entitlement to Medicare or Medicaid that causes a loss of coverage.

(iii) a "significant" increase in the cost of any benefit under the Plan.

**Note: If the cost of a health and welfare plan increases or decreases during the Plan Year, this Plan may, on a reasonable and consistent basis, automatically change your premium contributions in response to the change in cost.*

(iv) elimination or "significant" cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.

(v) your failure to make the required premium payment. Your election will be canceled but you will not be able to make a new election for the rest of the Plan Year.

(vi) your separation from service. If you terminate employment, you may cancel your election for any remaining period of coverage.

(vii) your enrollment in Marketplace coverage. If you enroll or intend to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll in a Marketplace plan effective immediately following the revocation. No change is permitted with regard to non-health benefits available under the Plan.

(viii) your permanent reduction of hours. If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll or intend to enroll in another plan no later than the first day of the second full month following the revocation. No change is permitted with regard to non-health benefits available under the Plan.

If you have a status change and you want to cancel or modify your election for a Plan Year, you must file a written application with the Plan Administrator within 30 days of the event, or within 60 days in the case of a special enrollment right due to the loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan. Keep in mind that any change to your election must be consistent with your status change. The Plan Administrator will consider your application and inform you of the decision.

Elections made under this Plan automatically terminate on the date on which you cease to be a participant in the Plan. In the event you become a participant again within 30 days of the date you stopped being a participant and before the end of the same Plan Year, the elections you previously had in effect shall automatically be reinstated for the balance of the Plan Year.

3.7 May I Make New Elections In Future Plan Years?

You will be provided an opportunity to change your elections for the underlying health and welfare benefits prior to the beginning of each Plan Year but do not need to renew your elections to participate in this Plan each year. So long as you remain enrolled in any underlying health and welfare benefits immediately prior to the Plan Year, you will be deemed to have elected to enroll in this plan for the following Plan Year and your compensation will be reduced to make pre-tax contributions for your share of the premiums for any underlying health and benefits you elect for the following Plan Year. However, if you wish to change any elections under this Plan in

future years, you must notify the Administrator during open enrollment prior to the beginning of the next Plan Year of your intent not to participate.

IV. BENEFITS

4.1 What Benefits Are Available Under The Plan?

Under the Plan, you may choose to receive your entire compensation in cash or use a portion to pay for any of the nontaxable benefits available under the Plan.

The nontaxable benefits under the Plan include pre-tax premium contributions provided under the Plan Sponsor's health and welfare plans available under this Plan, as designated and announced by the Plan Sponsor from time to time.

In the case of insured benefits, certain limits may apply on the amount of coverage that we obtain on your behalf. For example, it is possible, though unlikely, that even if you are a participant in the Plan, you might fail to qualify for coverage under the insured benefits offered under the Plan. Here, it is the insurance contracts, and not the terms of the Plan, which will dictate.

The Plan Sponsor may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts. We will not be liable to you if an insurance company fails to provide any of the benefits described above, even if the failure to provide benefits is due to our gross negligence (for example, if we fail to enroll you or pay premiums). In the case of health benefits, you may have a right by law to continue your benefits that would otherwise terminate when (i) you leave employment, (ii) you are no longer eligible under the terms of any group health plan or insurance policy, or (iii) when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after you have furnished the Plan Administrator with the necessary enrollment forms.

V. PREMIUM DEDUCTIONS

5.1 How Are Employee Premiums For Health And Welfare Plans Paid?

Upon your enrollment in the Employer's group health plan(s), you are automatically enrolled in the Plan unless you notify the Employer promptly, in a manner or on a form as prescribed by the Plan Administrator, that you do not wish to participate. Your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment (to the extent applicable) for the coverage selected under such plan(s).

VI. TERMINATION OF EMPLOYMENT

6.1 What Happens If My Employment is Terminated During The Plan Year?

If your employment is terminated during the Plan Year, you will remain covered by the Plan Sponsor's health and welfare plans, but only to the extent permitted under each such plan and only for the period for which premiums have been paid prior to your termination.

VII. HIGHLY COMPENSATED AND KEY EMPLOYEES

7.1 Do Limitations Apply To Those Who Are Highly Compensated?

Under the Internal Revenue Code, "highly compensated individuals," "highly compensated employees" and "key employees" are Participants who are generally highly paid employees. If you are within these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Plan experience will dictate whether contribution limitations on "highly compensated individuals," "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

VIII. GENERAL INFORMATION ABOUT THE PLAN

This section contains certain general information which you may need to know about the Plan.

8.1 General Plan Information

The name of the Plan is the City of Johnson City Section 125 Premium Only Plan (POP).

Your Plan's records are maintained on fiscal period known as the Plan Year. For this short plan year, the plan will run from October 1, 2021 to September 30, 2022. The plan year will run from October 1 to September 30 thereafter.

8.2 Employer Information

The Plan Sponsor's name, address, and identification number are:

City of Johnson City
303 E. Pecan Dr.
JOHNSON CITY, TX 78636
E.I.N.: 74-6003146

In addition to the Plan Sponsor, each entity listed below is a participating employer in this Plan:

None

8.3 Plan Administrator Information

The name, title, address, and business telephone number of your Plan Administrator is:

City of Johnson City
303 E. Pecan Dr.
JOHNSON CITY, TX 78636
Telephone: (830) 868-7111

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

8.4 Service Of Legal Process

The name and address of the Plan's agent for service of legal process is:

City of Johnson City
303 E. Pecan Dr.
JOHNSON CITY, TX 78636

8.5 Type Of Administration

The Plan is administered by the Plan Administrator, who may delegate administrative duties to a third-party administrator from time to time. As applicable, the Plan Administrator will notify you who the third-party administrator is, and any applicable contact information, when you join the Plan. The Plan Administrator may change the third-party administrator from time to time, and you will be notified of any such change.