SOUND CITIES ASSOCIATION

38 Cities. A Million People. One Voice.

SCA Board of Directors

AGENDA

September 21, 2022

Tukwila Community Center, Executive Conference Room

12424 42nd Ave S, Tukwila, WA 98168

10 AM - Noon

1)	**Call to Order –** President Angela Birney	2 minutes
2)	**Public Comment**	5 minutes
3)	**Consent Agenda**	3 minutes
	a. Minutes of the July 20, 2022 SCA Board of Directors Meeting	Attachment 1
	b. June 2022 Financial Reports	Attachments 2-3

Recommended Action: *Approval of the consent agenda consisting of the minutes of the July 20, 2022 SCA Board of Directors Meeting, and the June 2022 Financial Reports*

4)	**President's Report –** President Angela Birney	5 minutes
5)	**Executive Director's Report –** Brian Parry, Interim Executive Director	5 minutes
6)	**Treasurer's Report –** Treasurer Jeff Wagner	10 minutes
	a. July 26, 2022 Finance Committee Meeting Materials	
	b. Sponsorship Update	Attachment 4
	c. 2023-2024 Office Lease	Attachment 5
	d. 2023 Budget Update	
7)	**PIC Chair's Report –** PIC Chair Bill Boyce	10 minutes
	September 14, 2022 Public Issues Committee Meeting Materials	
	a. Board and Committee Appointment Process FAQ	
	b. DVI Awareness Month	
	c. Commercial Aviation Capacity	
8)	**Regional Homelessness Authority Update –** President Birney	5 minutes
9)	**City Manager's Report –** Carl Cole	5 minutes Attachment 6
10)	**Leadership Advisory Council Update –** President Birney	5 minutes
11)	**Equity and Inclusion Cabinet Update –** Cabinet Chair Prince	5 minutes

12) Legislative Committee Update – President Birney — 5 minutes

a. 2022 SCA Legislative Agenda — Attachment 7

Recommended Action: *Appointment of the 2022-2023 Legislative Committee consisting of SCA Board Members Angela Birney, James McNeal, Ed Prince, Mary Lou Pauly, Jan Molinaro, and De'Sean Quinn.*

13) Executive Session to Discuss Personnel Matter — 15 minutes

14) Discussion Items/Updates — 30 minutes

a. SCA Executive Director Recruitment Process Update
b. Administrative Assistant Hiring Update
c. Call for Nominations Update
d. Board Elections
e. 2023 Board Leadership
f. New FSA Plan Agreement — Attachment 8

Recommended Action: *Approval of FSA Plan with effective date of January 1, 2023, as provided by new vendor, Rehn & Associates.*

g. Upcoming Events
   i.) SCA Networking Dinner with Brian Surratt, Greater Seattle Partners President and CEO – Wednesday, October 5, 2022 – 6:00 to 8:00 PM – Renton Pavilion Events Center
   ii.) SCA Public Issues Committee Meeting – Wednesday, October 12, 2022 – 7:00 to 9:00 PM
   iii.) SCA Board of Directors Meeting – Wednesday, October 19, 2022 – 10:00 AM to Noon – Tukwila Community Center
   iv.) SCA Annual Meeting with Hilary Franz, Washington State Commissioner of Public Lands – Wednesday, November 30, 2022 – 5:30 to 8:00 PM – Renton Pavilion Events Center
h. 2022 SCA Accomplishments
i. 2022 SCA Board Retreat
   i.) Review 2022 Commitments — Attachment 9
   ii.) Equity and Inclusion
   iii.) Other

15) For the good of the order — 10 minutes

16) Adjourn

Sound Cities Association

Mission

To provide leadership through advocacy, education, mutual support and networking to cities in King County as they act locally and partner regionally to create livable vital communities.

Vision

Capitalizing on the diversity of our cities to lead policy change to make the Puget Sound region the best in the world.

Values

SCA aspires to create an environment that fosters mutual support, respect, trust, fairness and integrity for the greater good of the association and its membership. SCA operates in a consistent, inclusive, and transparent manner that respects the diversity of our members and encourages open discussion and risk-taking.

Guiding Principles

- Assume that others are acting with good intent
- No surprises!
- Have each other's backs
- Think about who is not at the table
- Be candid, but kind
- Once a decision is made, work together to make it work
- Show up to meetings prepared
- Be fully present and engaged during meetings
- Extend grace to others – cut them some slack
- Remain open-minded
- Respect differing views

2022 Policy Priorities

- Economic Recovery
- Housing/Homelessness
- Infrastructure
- Equity and Inclusion
- Collaboration, Nonpartisan Cooperation

SOUND CITIES ASSOCIATION

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SCA Board of Directors

DRAFT Meeting Minutes

July 20, 2022
10 AM - Noon
Tukwila Community Center, Executive Conference Room

1) Call to order

SCA President Angela Birney called the meeting to order at 10:15 AM. Present were Angela Birney, Jan Molinaro, Jeff Wagner, Mary Lou Pauly, Traci Buxton, Jim Ferrell, Carl Cole, De'Sean Quinn. Absent were members Amy Ockerlander, James McNeal, Bill Boyce, Wendy Weiker, and Ed Prince. Amy Ockerlander joined at 10:52 AM during item 8.b.

2) Public Comment

President Birney asked if there were any members of the public present for comment. Hearing none, this portion of the agenda was closed.

3) Consent Agenda

President Birney asked for any questions or concerns regarding the minutes of the June 15, 2022 SCA Board of Directors Meeting; and the May 2022 financial reports, consisting of the May 2022 Balance Sheet and May 2022 Profit & Loss Report.

Wagner moved, seconded by Ferrell, to approve the consent agenda consisting of the minutes of the June 15, 2022 SCA Board of Directors Meeting; and the financial reports of May 2022. The motion passed unanimously.

4) President's Report

President Birney updated group on recent events and meetings, and thanked Vice President Molinaro for inviting mayors and local leaders to fair event. Birney provided an update on Executive Director recruitment. Birney reminded the group of upcoming board elections and asked that members be considering possible recruitment for open spots, as well as leadership positions for 2023.

5) Executive Director's Report

Interim Executive Director Brian Parry reported on recent and upcoming meetings and events and encouraged members to attend. Parry noted need for members to serve on the SCA legislative committee and asked those interested in volunteering to communicate with staff.

6) 2023 Member City Dues, Assessment Rate

Interim Executive Director Brian Parry reviewed for the group draft proposed member city dues for 2023, as provided in the board meeting materials. Caps on population and CPI-W adjustment were recently updated in the SCA Board Policies. Draft 2023 dues reflect these changes of 90,000 and 5%, respectively. Parry asked for any questions or concerns. After discussion, the board took the following action:

Wagner moved, seconded by Ferrell, a recommendation of approval of the 2023 assessment rate and proposed member dues to the membership at the SCA Annual Meeting, and direction to staff to circulate the recommended rate and dues to member cities. The motion passed unanimously.

7) Treasurer's Report

a. SCA Treasurer Jeff Wagner summarized the June 26, 2022 Finance Committee Meeting Materials.

b. Wagner summarized sponsorships, including total sponsorship income received to-date; sponsorship payments received since the last meeting of the board; and status of outstanding sponsorship invoices. SCA is on track to be on budget for sponsorship income for 2022.

c. Staff gave update on investment account, noting funds had been successfully transferred and account has been opened.

d. Wagner reported that a lease renewal for 2023-2024 of the SCA office has been accepted by the Tukwila city council. This will be brought to the next meeting of the SCA finance committee for recommendation to the full board.

e. There were no other updates.

8) PIC Chair's Report

As PIC Chair Boyce was not present, Interim Executive Director Brian Parry reported on the July 13, 2022 Public Issues Committee (PIC) Meeting (Meeting Materials).

a. Parry reported that PIC voted to cancel the August 2022 meeting.

b. Parry reported that the PIC recommended appointments to SCA Regional Boards and committees. After discussion, the board took the following action:

Wagner moved, seconded by Ferrell to appoint members to regional boards and committees, as recommended by PIC, as follows:

- ***Councilmember Vanessa Kritzer, Redmond, to fill a vacant SCA Member position on the Regional Transit Committee.***
- ***Councilmember Paul Charbonneau, Newcastle, to fill a vacant SCA Alternate position on the Regional Transit Committee.***
- ***Councilmember Didem Pierson, Maple Valley, to fill a vacant SCA Alternate position on the Emergency Management Advisory Committee.***

- ***Councilmember Karen Howe, Sammamish, to fill a vacant SCA Member position on the King County Flood Control District Advisory Committee***

The motion passed unanimously.

c. Parry reported on King County's Wastewater Treatment Division (WTD) developing a Clean Water Plan (CWP) and reviewed the Draft SCA Clean Water Plan Guiding Principles, as provided in the meeting materials. Parry noted appreciation for work by SCA Policy Analyst Kazia Mermel and by members of the Regional Water Quality Committee (RWQC) on putting the principles together. After discussion, the board took the following action:

Wagner moved, seconded by Ferrell Adoption of the SCA Clean Water Plan Guiding Principles, as recommended by PIC. The motion passed unanimously.

d. Parry summarized update on 988 Crisis System, and other upcoming and potential changes to behavioral health policies.

e. Parry reported on levies and ballot issues in King County and asked members to share any levies and ballot measures in their own cities with SCA staff.

f. Members reported on summer events attended, including the AWC Annual Conference. There was no further discussion on this item.

9) Regional Homelessness Authority Update

President Birney reported on the Regional Homelessness Authority (KCRHA), noting no changes to report since last updating the board at the June meeting. Birney reiterated that the SCA members on governing board welcome feedback and input. The governing board members and SCA staff will continue to provide updates.

10) City Administrator's Report

City Manager/ Administrator Representative Carl Cole reported on the July 2022 CM/CA Meeting. Discussion topics included presentation from AWC CEO Deanna Dawson; legislative update from Candice Bock, AWC; discussion regarding public records best practices; and discussion on future meeting format. There is no August 2022 CM/CA meeting.

11) Leadership Advisory Council

President Birney reported that the Leadership Advisory Council continues to meet monthly. There were no updates to report.

12) Equity and Inclusion Cabinet

As Equity and Inclusion Cabinet Chair Ed prince was not present, Interim Executive Director Brian Parry reported that the group met on July 29, 2022. A call for nominations for a vacancy on the cabinet has been sent out. Parry asked for direction from board members regarding potential proclamation suggested by the

Equity and Inclusion Cabinet. President Birney noted cabinet was created to advise the board, and intended to be advisory to board. After substantial discussion, board decided to make no action at this time.

There were no other updates.

13) Discussion Items/Updates

a. After discussion, the board took the following action:

Wagner moved, seconded by Ferrell to cancel the August 2022 SCA Board of Directors meeting. The motion passed unanimously.

b. SCA Interim Executive Director Brian Parry gave brief update on the Executive Director recruitment. Position has been posted by the recruiting firm, and recruitment process is proceeding as planned. This item was also discussed earlier in the agenda, under the President's Report.

c. SCA Chief Operating Officer Leah Willoughby gave brief update on Administrative Assistant recruitment. Job opening has been posted and staff will be reviewing applications beginning on August 1, 2022. Staff hopes to fill the position by the fall. Members were asked to share the opportunity with any appropriate networks or individuals that might be interested in applying.

d. 2023 Member City Dues
This item was discussed earlier in the agenda.

e. AWC Housing Solutions Group
SCA Interim Executive Director Brian Parry reported that the Association of Washington Cities was recruiting members to serve on its Housing Solutions Group and encouraged interested board members to apply.

f. Board Elections
This item was discussed earlier in the agenda, under the President's Report. SCA Interim Executive Director Brian Parry reiterated request for board members to be considering new members and leadership positions for 2023.

g. Regional Airport Capacity
SCA Interim Executive Director Brian Parry reported on recent work by the state related to regional airport capacity.

h. 2022 SCA Accomplishments
President Birney asked members to continue to consider accomplishments of SCA in 2022. This item will be brought back for discussion at the next meeting of the board.

i. 2022 SCA Board Retreat

i.) Review 2022 Commitments

Members checked in regarding progress with 2022 commitments. This item will continue to be brought back for discussion at future meetings.

ii.) Equity and Inclusion

This item was discussed earlier in the agenda.

iii.) Other

There were no other updates.

14) For the Good of the Order

Amy Ockerlander noted that Duvall had appointed new councilmember.

There were no other items for the good of the order.

15) Meeting was adjourned by President Birney at 11:58 AM.

SOUND CITIES ASSOCIATION
Balance Sheet
As of June 30, 2022

1110 HomeStreet Bank		352,387.37
1120 HomeStreet Bank - Money Market		457,603.29
1130 PayPal Bank		0.00
1140 Time Value Investments		300,000.00
Total Bank Accounts	**$**	**1,109,990.66**
Total Accounts Receivable	**$**	**22,000.00**
1499 Undeposited Funds		0.00
1550 Prepaid Expenses		0.00
Total Other Current Assets	**$**	**0.00**
Total Current Assets	**$**	**1,131,990.66**
1410 Furniture and Fixtures		31,060.23
1415 Computers		4,891.71
1420 Accumulated Depreciation		-33,938.51
Total 1400 Fixed Assets	**$**	**2,013.43**
Total Fixed Assets	**$**	**2,013.43**
Other Long-term Assets		0.00
Total Other Assets	**$**	**0.00**
TOTAL ASSETS	**$**	**1,134,004.09**
Total Accounts Payable	**$**	**231.06**
2200 HomeStreet Credit Card		6,938.21
Total Credit Cards	**$**	**6,938.21**
2300 Accrued Payroll		**9,638.80**
2110 Federal Withholding		0.00
2111 Direct Deposit Liabilities		0.00
Total 2140 Medicare	$	0.00
2150 SDI		0.00
2405 FUTA		334.49
2410 SUI		720.94
Total 2415 FIT, SS, Medicare - 941	$	4,699.85
2420 L&I		685.23
2425 WA Paid Family & Medical Leave		520.51
2435 PERS Payable		7,309.16
2440 DCAP / FSA Payable		-208.40
2445 DRS DCP Payable		262.50
2450 Medical/Dental/Vision/Life Ins		-799.53
2460 Accrued Vacation Pay		72,523.76
2470 w/held VLTD Buy Up		0.00
2499 Payroll Corrections		0.00
Car Allowance Payable		0.00
Total 2400 Payroll Liabilities	**$**	**86,048.51**
Deferred Revenue		0.00
Total Other Current Liabilities	**$**	**95,687.31**
Total Current Liabilities	**$**	**102,856.58**
Total Liabilities	**$**	**102,856.58**
3110 Equipment Purchase Reserve		15,000.00
3120 Operations Reserves		428,767.00
3130 Contractual Obligations Reserve		106,194.00
3140 Legal Reserves Fund		25,000.00
Total 3100 Board Designated Reserves	**$**	**574,961.00**
3200 Board Designated Contra		-574,961.00
3300 Fund Balance (Prior Years)		721,782.37
3999 Opening Bal Equity		0.00
Net Income		309,365.14
Total Equity	**$**	**1,031,147.51**
TOTAL LIABILITIES AND EQUITY	**$**	**1,134,004.09**

Accrual Basis Lw

SOUND CITIES ASSOCIATION
Profit and Loss by Month
January - June, 2022

	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Total	2022 Budget	Difference
1010 Member Dues	749,539.23						749,539.23	749,539.22	0.00
1020 Membership/Sponsorships	86,000.00	9,500.00	4,000.00	3,000.00	1,000.00		103,500.00	97,000.00	6,500.00
1030 Registration/Dinners Revenue			5,560.00			0.00	5,560.00	10,000.00	-4,440.00
1040 Interest Income	70.58	99.46	118.71	114.53	112.55	98.25	614.08	1,000.00	-385.92
1150 CC Points Redeemed for Credit		275.00			225.00		500.00	0.00	500.00
Total Income	**$ 835,609.81**	**$ 9,874.46**	**$ 9,678.71**	**$ 3,114.53**	**$ 1,337.55**	**$ 98.25**	**$ 859,713.31**	**$ 787,093.00**	**2,174.08**
Gross Profit	**$ 835,609.81**	**$ 9,874.46**	**$ 9,678.71**	**$ 3,114.53**	**$ 1,337.55**	**$ 98.25**	**$ 859,713.31**		

								2022 Budget	Difference	% Budget Remaining	
Total 5100 Salaries	**$ 47,791.20**	**$ 47,791.21**	**$ 47,791.16**	**$ 47,791.16**	**$ 47,792.87**	**$ 179,050.31**	**$ 418,007.91**	**573,494.00**	**155,486.09**	**27%**	**Total 5100 Salaries**
5210 Taxes-FUTA	83.34	0.00	0.00	0.00	0.00	0.00	83.34	210.00	126.66	60%	5210 Taxes-FUTA
5220 Taxes-SUTA	385.46	342.01	353.19	262.47	215.66	166.08	1,724.87	1,695.00	-29.87	-2%	5220 Taxes-SUTA
5230 Taxes - FICA, Medicare - 941	3,687.14	3,662.41	3,662.39	3,662.38	3,684.74	7,988.96	26,348.02	37,766.00	11,417.98	30%	5230 Taxes - FICA, Medicare - 941
5240 Taxes - L & I	30.61	137.65	137.65	173.38	101.95	81.56	662.80	1,745.00	1,082.20	62%	5240 Taxes - L & I
5250 Taxes-FMLA	122.16	122.16	122.16	122.16	122.90	214.27	825.81	2,058.00	1,232.19	60%	5250 Taxes-FMLA
Total 5200 Payroll Taxes	**$ 4,308.71**	**$ 4,264.23**	**$ 4,275.39**	**$ 4,220.39**	**$ 4,125.25**	**$ 8,450.87**	**$ 29,644.84**	**43,474.00**	**13,829.16**	**32%**	**Total 5200 Payroll Taxes**
5310 Pension Plan Contributions	4,898.60	4,898.60	4,898.60	4,898.60	4,928.50	3,927.68	28,450.58	58,783.00	30,332.42	52%	5310 Pension Plan Contributions
5320 Medical/Dental/Vision/Life Ins	5,284.80	5,284.80	5,284.80	5,284.80	5,284.80	4,485.33	30,909.33	63,504.00	32,594.67	51%	5320 Medical/Dental/Vision/Life Ins
5330 Professional Development				819.95	29.95	29.95	879.85	5,000.00	4,120.15	82%	5330 Professional Development
Total 5340 Travel Reimburse	$ 500.00	$ 500.00	$ 500.00	$ 500.00	$ 500.00	$ 600.59	$ 3,100.59	10,000.00	6,899.41	69%	Total 5340 Travel Reimburse
Total 5300 Staff Benefits	**$ 10,683.40**	**$ 10,683.40**	**$ 10,683.40**	**$ 11,503.35**	**$ 10,743.25**	**$ 9,043.55**	**$ 63,340.35**	**137,287.00**	**73,946.65**	**54%**	**Total 5300 Staff Benefits**
Total 5000 Staff	**$ 62,783.31**	**$ 62,738.84**	**$ 62,749.95**	**$ 63,514.90**	**$ 62,661.37**	**$ 196,544.73**	**$ 510,993.10**	**754,255.00**	**243,261.90**	**32%**	**Total 5000 Staff**
6100 Rent	2,639.84	2,639.84	2,639.84	2,639.84	2,639.84	2,639.84	15,839.04	**31,678.00**	**15,838.96**	**50%**	**6100 Rent**
6310 Copier/Printer Lease & Maint	231.06	231.06	231.06	231.06	231.06	231.06	1,386.36	2,960.00	1,573.64	53%	6310 Copier/Printer Lease & Maint
6320 Outside Printing & Publication			266.66	22.24			288.90	600.00	311.10	52%	6320 Outsourced Printing/Publications
Total 6300 Printing and Publication	**$ 231.06**	**$ 231.06**	**$ 497.72**	**$ 253.30**	**$ 231.06**	**$ 231.06**	**$ 1,675.26**	**3,560.00**	**1,884.74**	**53%**	**Total 6300 Printing and Publication**
6420 Website Design/Hosting	30.00	30.00	30.00	77.33	30.00	30.00	227.33	1,400.00	1,172.67	84%	6420 Website Design/Hosting
6430 IT Equipment		1,779.45					1,779.45	2,000.00	220.55	11%	6430 Equipment
6440 Software/Subscriptions	1,092.52	405.01	216.42	228.98	228.98	1,743.44	3,915.35	4,982.00	1,066.65	21%	6440 Software/Subscriptions
Total 6400 IT	**$ 1,122.52**	**$ 2,214.46**	**$ 246.42**	**$ 306.31**	**$ 258.98**	**$ 1,773.44**	**$ 5,922.13**	**8,382.00**	**2,459.87**	**29%**	**Total 6400 IT**
6500 Cell Phone Service	256.50	256.10	256.10	256.05	255.90	255.90	1,536.55	**3,060.00**	**1,523.45**	**50%**	**6500 Cell Phone Service**
6600 CC, Banking & Other Fees	5.00	5.00	5.00	5.00	104.00	40.00	164.00	**150.00**	**-14.00**	**-9%**	**6600 CC, Banking & Other Fees**
Total 6700 Accounting Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**2,570.00**	**2,570.00**	**100%**	**Total 6700 Accounting Fees**
6800 Legal Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**5,000.00**	**5,000.00**	**100%**	**6800 Legal**
6900 Office Supplies / Misc.	33.58	26.21	282.04	354.55	43.68	395.23	1,135.29	**2,500.00**	**1,364.71**	**55%**	**6900 Office Supplies / Misc.**
Total 6000 Office / Overhead	**$ 4,288.50**	**$ 5,372.67**	**$ 3,927.12**	**$ 3,815.05**	**$ 3,533.46**	**$ 5,335.47**	**$ 26,272.27**	**56,900.00**	**30,627.73**	**54%**	**Total 6000 Office / Overhead**
7100 Food/Beverage/Rentals				4,395.67			4,395.67	5,000.00	604.33	12%	7100 Event food/bev/rentals
7200 Event Pmts Processing Fee			308.22	24.28		0.00	332.50	0.00	-332.50		
Total 7000 Event Expenses	**$ 0.00**	**$ 0.00**	**$ 308.22**	**$ 4,419.95**	**$ 0.00**	**$ 0.00**	**$ 4,728.17**	**10,000.00**	**5,271.83**	**53%**	**Total 7000 Event Expenses**
8100 Insurance (D&O)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1,774.00	1,774.00	100%	8100 D&O Insurance
8200 Awards / Recognition			0.00				0.00	1,000.00	1,000.00	100%	8200 Awards / Recognition
8300 Retreats/Mtgs/Conf/Dues/Events	521.11	1,500.00	1,952.33	-434.51	150.23	3,136.68	6,825.84	13,000.00	6,174.16	47%	8300 Retreats/Mtgs/Conf/Dues/Events
8400 Consultants/Special Projects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,000.00	5,000.00	100%	8400 Consultants/Special Projects
Total 8000 Board / Org Development	**$ 521.11**	**$ 1,500.00**	**$ 1,952.33**	**-$ 434.51**	**$ 269.23**	**$ 3,151.71**	**$ 6,959.87**	**20,774.00**	**13,814.13**	**66%**	**Total 8000 Board / Org Development**
9000 Contingency Fund		0.00			363.26	76.00	439.26	15,000.00	14,560.74	97%	Contingency Fund
Depreciation	159.25	159.25	159.25	159.25	159.25	159.25	955.50				
Total Expenses	**$ 67,752.17**	**$ 69,770.76**	**$ 69,096.87**	**$ 71,474.64**	**$ 66,986.57**	**$ 205,267.16**	**$ 550,348.17**	**857,533.00**	**307,184.83**	**36%**	**Total Expenses**
Net Operating Income	**$ 767,857.64**	**-$ 59,896.30**	**-$ 59,418.16**	**-$ 68,360.11**	**-$ 65,649.02**	**-$ 205,168.91**	**$ 309,365.14**				
Net Income	**$ 767,857.64**	**-$ 59,896.30**	**-$ 59,418.16**	**-$ 68,360.11**	**-$ 65,649.02**	**-$ 205,168.91**	**$ 309,365.14**				

Accrual Basis LW

Sponsorship Payment Tracking
2022

Sponsorship Level	Sponsor/Entity	Invoiced Month	Amount Invoiced	Paid Month	Amount Paid
Partner	Amazon	February 2022	$ 6,000.00	July 2022	$ 6,000.00
Regional Associate Member	AT&T	February 2022	$ 500.00	July 2022	$ 500.00
Regional Associate Member	AWC	January 2022	$ 500.00	January 2022	$ 500.00
Partner	Boeing	January 2022	$ 6,000.00	May 2022	$ 6,000.00
Event Sponsor	Boeing	January 2022	$ 2,500.00	May 2022	$ 2,500.00
Partner	Cedar Grove	January 2022	$ 6,000.00	February 2022	$ 6,000.00
Partner	Comcast	January 2022	$ 6,000.00	May 2022	$ 6,000.00
Event Sponsor	Comcast	January 2022	$ 2,500.00	May 2022	$ 2,500.00
Regional Associate Member	Creative Solutions			In-Kind	
Regional Associate Member	Desimone Consulting Group	March 2022	$ 500.00	July 2022	$ 500.00
Regional Associate Member	EMC Research	January 2022	$ 500.00	February 2022	$ 500.00
Partner	Facebook	January 2022	$ 3,000.00		
Partner	Facebook	January 2022	$ 3,000.00	January 2022	$ 3,000.00
Regional Associate Member	Foster Garvey	February 2022	$ 500.00	March 2022	$ 500.00
Event Sponsor	Foster Garvey	February 2022	$ 2,500.00	March 2022	$ 2,500.00
Regional Associate Member	Gordon Thomas Honeywell	April 2022	$ 500.00	June 2022	$ 500.00
Event Sponsor	Gordon Thomas Honeywell	April 2022	$ 2,500.00	June 2022	$ 2,500.00
Regional Associate Member	Green River College	January 2022	$ 500.00	July 2022	$ 500.00
Event Sponsor	Inslee Best	January 2022	$ 2,500.00	February 2022	$ 2,500.00
Regional Associate Member	Inslee Best	January 2022	$ 500.00	February 2022	$ 500.00
Regional Associate Member	The Johnston Group	January 2022	$ 500.00	February 2022	$ 500.00
Regional Associate Member	Jurassic Parliament			In-Kind	
Regional Associate Member	KC Dept of Assessments	January 2022	$ 500.00	January 2022	$ 500.00
Regional Associate Member	King Conservation District	January 2022	$ 500.00		
Regional Associate Member	King County Elections	May 2022	$ 500.00	June 2022	$ 500.00
Regional Associate Member	King County Library Systems	January 2022	$ 500.00	February 2022	$ 500.00
Regional Associate Member	Langton Spieth, LLC	January 2022	$ 500.00	January 2022	$ 500.00
Partner	Lumen	August 2021	$ 6,000.00	August 2021	$ 6,000.00
Partner	Marketing Solutions			In-Kind	
Regional Associate Member	Michael Baker International	January 2022	$ 500.00	March 2022	$ 500.00
Partner	Microsoft	January 2022	$ 6,000.00	February 2022	$ 6,000.00
Regional Associate Member	Outcomes by Levy	January 2022	$ 500.00	January 2022	$ 500.00
Partner	Port of Seattle	January 2022	$ 6,000.00	January 2022	$ 6,000.00
Regional Associate Member	PRR	March 2022	$ 500.00	May 2022	$ 500.00
Partner	Puget Sound Energy	January 2022	$ 6,000.00	February 2022	$ 6,000.00
Partner	Recology	January 2022	$ 6,000.00		
Partner	Republic Services	January 2022	$ 6,000.00	April 2022	$ 6,000.00
Regional Associate Member	SAP Concur	May 2022	$ 500.00		
Regional Associate Member	Seattle Building and Constr.	January 2022	$ 500.00	January 2022	$ 500.00
Partner	Seattle King County Realtors	September 2021	$ 6,000.00		
Partner	Seattle Metro Chamber	September 2022	$ 6,000.00		
Partner	Sound Transit	January 2022	$ 6,000.00	July 2022	$ 6,000.00
Regional Associate Member	Symetra	March 2022	$ 3,000.00	May 2022	$ 3,000.00
Regional Associate Member	ValleyCom	January 2022	$ 500.00	February 2022	$ 500.00
Partner	Waste Management	January 2022	$ 6,000.00	February 2022	$ 6,000.00
TOTALS			**$ 115,500.00**		**$93,500.00**

City of Tukwila

6200 Southcenter Boulevard, Tukwila WA 98188

Agreement Number:

LEASE AGREEMENT

THIS LEASE AGREEMENT is made between the **City of Tukwila** ("the City" or "Lessor") and **Sound Cities Association** ("Sound Cities Association" or "Lessee").

IN CONSIDERATION OF the mutual benefits and conditions hereinafter contained, the parties hereto agree as follows:

1. **Premises**. Lessor is the owner of the commercial property located at 6300 Southcenter Boulevard, Tukwila, Washington (the "Property"). Lessor does hereby agree to lease to Lessee, a portion of the Property consisting of approximately 1,460 rentable square feet (the "Premises"). The Premises do not include the exterior walls, roof, land beneath, pipes, ducts, conduits, wires, fixtures and equipment above the suspended ceiling, or any other portion of the Property or the buildings thereon. The City and Lessee agree that the Lessee's pro-rata share of the Property that the Premises are a part of is 3.45%, based on the ratio of the agreed rentable area of the Premises to the agreed rentable area of the entire Property as of the date of this Lease.

2. **Term**. This Agreement shall be in full force and effect for a period commencing January 1, 2023 and ending December 31, 2024, unless sooner terminated under the provisions set forth in Section 22. Upon termination of this Lease the Lessee shall surrender all keys and/or access cards to the City.

3. **Possession**. Lessee shall be deemed to have accepted possession of the Premises in an "as-is" condition. The City makes no representations to Lessee regarding the Premises including the structural condition of the Premises and the condition of all mechanical, electrical and other systems. Lessee shall be responsible for performing any work necessary to bring the Premises into condition satisfactory to Lessee. Lessee shall not engage in any improvements or alterations to the Premises without the express written consent of the City.

4. **Rent**. Base rent shall be set at $18.50 per square feet per year, or $27,010.00 per year, to be paid in monthly installments of $2,250.83 for the period of January 1, 2023 – December 31, 2023 and $19.00 per square feet per year, or $27,740.00 per year, to be paid in monthly installments of $2,311.67 for the period of January 1, 2024 – December 31, 2024. Rent shall be due on the first day of each month. If payment is not received by the fifth day of each month, Lessee shall be responsible for paying a late fee equivalent to five percent (5%) of the delinquent amount in addition to the past due payment. All delinquent sums not paid within thirty (30) days of the due date shall bear interest at the rate of twelve percent (12%) per annum. Interest on all delinquent amounts shall be calculated from the original due date to the date of payment. The City's acceptance of less than the full amount of any payment due

from Lessee shall not be deemed an accordance and satisfaction or compromise of such payment.

5. **Leasehold Excise Tax**. Lessee shall pay leasehold excise tax due pursuant to RCW 82.29A to Lessor by the first day of each month at the rate of 12.84% of the base rent set forth in Section 4 herein, such amount being $289.00 per month for January 1, 2023 – December 31, 2023 and $296.50 per month for January 1, 2024 – December 31, 2024. The leasehold excise tax shall be paid in addition to the monthly rental payment and any other payments required under this Lease. If the State of Washington changes the leasehold excise tax, the tax payable by the Lessee each month under this Lease shall be correspondingly modified in compliance with RCW 82.29A without further action by the parties.

6. **Use of Premises by Lessee**. Lessee shall use the Premises for general office use. The Premises shall be used only for the uses specified herein and for not for any other business or purpose without the prior written consent of the City. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises or cause the cancellation of any insurance on the Premises. Lessee shall not commit or allow to be committed any waste upon the Premises or any public or private nuisance. Lessee shall not do or permit anything to be done on the Premises which will obstruct, cause injury or interfere with the rights of other tenants, or occupants of the Premises or their customers, clients and visitors.

7. **Lessee Maintenance and Repair Responsibility**. Lessee shall, when and if needed, at Lessee's sole expense, make repairs to the Premises and every part thereof; and Lessee shall maintain the Premises in a neat, clean, sanitary condition. Lessee shall surrender the Premises to the City in good condition upon the termination of this Lease, reasonable wear and tear expected.

8. **Signage**. Lessee shall obtain the City's written consent before installing any signs on the Premises and shall install any approved signage at Lessee's sole expense and in compliance with all applicable laws. Lessee shall not damage or deface the Premises when installing or removing signage and shall repair any damage to the Premises caused by such installation or removal.

9. **Utilities, Equipment and Services**. The City shall provide the Premises with the following services, the cost of which shall be included in the rent paid by Lessee: water, electricity, and heating/cooling seven (7) days per week and janitorial services five (5) nights per week, exclusive of holidays.

The Lessee shall pay the City $110 per month for internet service, payable on the first of each month along with rent.

The City's Technology Services department shall provide the Lessee with basic technology support to maintain hardware equipment and software applications, such support being performed during the City's regular, non-holiday business hours of 8:30 a.m. to 5:00 p.m. Any after-hours emergency callouts or mutually agreed upon project work will be billed in one-hour increments at a flat rate of $150/hour with a minimum charge of one hour. Charges will be invoiced upon completion of the work and will be payable within 30-days.

The City shall provide six (6) extensions to the City phone system for use by the Lessee and will maintain the phone system at no additional cost to the Lessee. Lessee shall be responsible for all costs associated with long distance and other toll calls which may be billed separately by the City. Charges will be invoiced upon receipt of phone bill and will be payable within 30-days.

On an annual basis, the Lessee shall provide an inventory list to the City detailing hardware equipment and software utilized by the Lessee. Any hardware equipment or software requested for purchase by the City to update the Lessee's inventory will be billed to the Lessee at actual cost. Any hardware equipment or software purchased by the Lessee shall be reviewed by the City's Technology and Innovation Service Center for system compatibility and supportability prior to purchase and installation.

Virus checking software and that has been approved by the City's Technology and Innovation Service Center is mandatory on all Lessee computers, laptops and servers in use by the Lessee. Any virus signature files released by the virus checking software company shall be set to automatically update to keep the Lessee's software updated to the latest version available.

A data backup program approved by the City's Technology and Innovation Service Center is mandatory and will be configured to automatically back up any of the Lessee's server-based live, primary data. Data that is stored only locally (on computers, laptops, phones, tablets) will NOT be backed up nor monitored at the Lessee's own risk. The performance of the backup program will be monitored and tested on a quarterly basis by both parties.

10. **Destruction of Premises**. If the Premises are completely or partially destroyed by fire or other casualty, of if they are damaged by an uninsured casualty, or by an insured casualty to such an extent that the damage cannot be repaired within sixty (60) days of the occurrence, the City shall have the option to restore the Premises or to terminate this Agreement on thirty (30) days written notice, effective as of any date not more than sixty (60) days after the occurrence. If this Section becomes applicable, the City shall advise the Lessee within thirty

(30) days after such casualty whether the City elects to restore the Premises or to terminate this Agreement. If the City elects to restore the Premises, it shall commence and complete the restoration work with due diligence. For the period from the date of the casualty until completion of the repairs (or the date of termination of this Agreement, if the City elects not to restore the Premises) the monthly base rent shall be abated in the same proportion that the untenantable portion of the Premises bears the whole thereof, unless the casualty results from Lessee's negligence or its breach of obligations under this Agreement.

11. **Hazardous Substances**. Lessee shall not generate, release, spill, store, deposit, transport or dispose of (collectively "Release") any hazardous substances, sewage, petroleum products, radioactive substances, medicinal, bacteriological, or disease-producing substances, hazardous materials, toxic substances or any pollutants or substances defined as hazardous or toxic in accordance with applicable federal, state and local laws and regulations in any reportable quantities (collectively "Hazardous Substances") in, on or about the Premises. Lessee shall attach a separate list of Hazardous Substances they propose to store on site and the City must accept the list in writing or Hazardous Substances cannot be stored on site. The Lessee shall indemnify, hold harmless and defend the City from any and all claims, liabilities, losses, damages, clean-up costs, response costs and expenses, including reasonable attorneys' fees, arising out of or in any way related to the Release by the Lessee or any of its agents, representatives or employees, or to the presence of such Hazardous Substances in, on or about the Premises occurring at any time after the effective date of this Agreement to the full extent of the Lessee's liability.

12. **Alterations and Additions**. After obtaining the prior written consent of the City, Lessee may make, at its sole expense, such additional improvements or alterations to the Premises which it may deem necessary or desirable. Any repairs or new construction done by Lessee shall be done in conformity with plans and specifications approved by the City. All work performed shall be done in a workmanlike manner and shall become the property of the City.

13. **Liens**. Lessee shall keep the Premises free from any liens arising out of any work performed, materials furnished, or obligations incurred by Lessee.

14. **Insurance**. The Lessee shall procure and maintain for the duration of the Lease, insurance against claims for injuries to persons or damage to property which may arise from or in connection with the Lessee's operation and use of the leased Premises.

a. No Limitation

The Lessee's maintenance of insurance as required by the Lease shall not be construed to limit the liability of the Lessee to the coverage provided by such insurance, or otherwise limit the City's recourse to any remedy available at law or in equity.

b. Minimum Scope of Insurance. The Lessee shall obtain insurance of the types described below:
   i. Commercial General Liability insurance shall be at least as broad as Insurance Services Office (ISO) occurrence form CG 00 01 and shall cover premises and contractual liability. The City shall be named as additional an insured on Lessee's Commercial General Liability insurance policy using ISO Additional Insured-Managers or Lessors of Premises Form CG 20 11 or a substitute endorsement providing at least as broad coverage.
   ii. Property insurance shall be written on an all risk basis.

c. Minimum Amounts of Insurance. Lessee shall maintain the following insurance limits:
   i. Commercial General Liability insurance shall be written with limits no less than $2,000,000 each occurrence, $2,000,000 general aggregate.
   ii. Property insurance shall be written covering the full value of the Lessee's property and improvements with no coinsurance provisions.

c. Other Insurance Provisions. The Lessee's Commercial General Liability insurance policy or policies are to contain or be endorsed to contain that they shall be primary insurance as respect to the City. Any insurance, self-insurance, or insurance pool coverage maintained by the City shall be in excess of the Lessee's insurance and shall not contribute with it.

d. Acceptability of Insurers. Insurance is to be placed with insurers with a current A.M Best rating of not less than A: VII.

e. Verification of Coverage. Lessee shall furnish the City with original certificates and a copy of any applicable amendatory endorsements including, but not necessarily limited to, the additional insured endorsement evidencing the insurance requirements of the Lessee.

f. Waiver of Subrogation. Lessee and the City hereby release and discharge each other from all claims, losses, and liabilities arising from or caused by any hazard covered by property insurance on or in connection with the Premises or said building. This release shall apply only to the extent that such claim, loss or liability is covered by insurance.

g. City's Property Insurance. The City shall purchase and maintain during the term of this Lease, all-risk property insurance covering the Building for full replacement value without any coinsurance provisions.

h. Notice of Cancellation. The Lessee shall provide the City with written notice of any policy cancellation, within two (2) business days of receiving such notice.

i. Failure to Maintain Insurance. Failure on the part of the Lessee to maintain the required insurance shall constitute a material breach of this Lease upon which the City may, after giving five (5) business days notice to the Lessee to correct the breach, terminate this Lease or, at its discretion, procure or renew such insurance and pay and all premiums in connection therewith, with any sums so expended to be repaid to the City on demand.

j. City Full Availability of Lessee Limits. If the Lessee maintains higher insurance limits than the minimums shown above, the City shall be insured for the full available limits of Commercial General and Excess or Umbrella liability maintained by the Lessee, irrespective of whether such limits maintained by the Lessee are greater than those required by this Lease or whether any certificate of insurance furnished to the City evidence limits of liability lower than those maintained by the Lessee.

15. **Indemnification and Hold Harmless.** Lessee shall defend, indemnify, and hold harmless the City, its officers, officials, employees and volunteers from and against any and all claims, suits, actions, or liabilities for injury or death of any person, or for loss or damage to property, which arises out of Lessee's use of Premises, or from the conduct of Lessee's business, or from any activity, work or thing done, permitted, or suffered by Lessee in or about the Premises, except only such injury or damage as shall have been occasioned by the sole negligence of the City. It is further specifically and expressly understood that the indemnification provided herein constitutes the Lessee's waiver of immunity under Industrial Insurance, Title 51 RCW, solely for the purposes of this indemnification. This waiver has been mutually negotiated and agreed to by the Lessee and City. The provisions of this section shall survive the expiration or termination of this Lease.

16. **Assignment and Subletting**. Lessee shall not assign this Lease or sublet any portion of the Premises. Any sublease or assignment made in violation of this provision shall be void.

17. **Default**. Failure by Lessee to observe or perform any of the covenants, conditions or provisions of this Lease, where such failure shall continue for a period of ten (10) days after written notice from the City to cure the default, shall constitute a default and breach of this Lease. Lessee shall notify the City promptly of any default not by its nature necessarily known to the City.

18. **Access**. After reasonable notice from the City (except in the cases of emergency where no notice is required) the Lessee shall permit the City and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, alterations, improvements or

inspections. This section shall not impose any repair or other obligation upon the City not expressly stated elsewhere in this Agreement.

19. **Compliance with Laws, Rules and Regulations**. Lessee shall, at its sole cost and expense, promptly comply with all laws, statutes, ordinances and governmental rules, regulations or requirements now in force or which may hereafter be in force relation to or affecting the conditions, use, or occupancy of the leased premises. Lessee shall faithfully observe and comply with City rules and regulations.

20. **Permits**. Lessee shall, at its sole cost and expense, be responsible for obtaining any required permits and licenses necessary to perform the work and covenants of this Lease.

21. **Notices**. All notices under this Lease shall be in writing and shall be effective when mailed by certified mail or delivered to the addresses listed below.

Notices to Lessor shall be sent to:	Notices to Lessee shall be sent to:
City of Tukwila	Sound Cities Association
ATTN: Mayor's Office	ATTN: Executive Director
6200 Southcenter Boulevard	6300 Southcenter Blvd, Suite 206
Tukwila WA 98188	Tukwila WA 98188

22. **Termination**. Either party may terminate this Agreement if the other party is in default as outlined in Section 17 or at any time on or before the expiration of this Lease by providing a minimum of thirty (30) days written notice to the other party.

23. **Applicable Law; Venue: Attorneys' Fees**. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington. In the event any suit, arbitration, or other proceeding is instituted to enforce any term of this Agreement, the parties specifically understand and agree that venue shall be in King County, Washington. The prevailing party in any such action shall be entitled to its attorneys' fees and costs of suit.

24. **Authority of Lessee**. The Lessee and the individual executing this Lease on behalf of the Lessee represent and warrant that s/he is duly authorized to execute and deliver this Lease and upon execution this Lease is binding upon the Lessee in accordance with the terms herein.

25. **Waiver and Forbearance**. No waiver by the City of any breach or default by the Lessee of any of its obligations or covenants herein shall be deemed to be a waiver of any subsequent breach or default of the same or any other obligation or covenant, nor shall forbearance by

the City to seek remedy for any break or default of the Lessee be deemed a waiver by the City of its rights and remedies with respect to such breach or default.

26. **Entire Agreement - Modification**. This Lease Agreement together with all exhibits or addenda expressly incorporated herein by reference and attached hereto shall constitute the whole agreement between the parties. There are no terms, obligations, covenants or conditions other than those contained herein. Except as otherwise provided, no modification or amendment of this Lease Agreement shall be valid or effective unless evidenced by an agreement in writing signed by both parties.

27. **Severability and Survival**. If any term, condition or provision of this Lease is declared void or unenforceable or limited in its application or effect, such event shall not affect any other provisions hereof and all other provisions shall remain fully enforceable.

CITY OF TUKWILA

By: _____
Allan Ekberg
Mayor

SOUND CITIES ASSOCIATION

By: _____
Executive Director

Attest:

By: _____
Christy O'Flaherty, City Clerk

Approved as to form:

By: _____
City Attorney

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

I certify that I know or have satisfactory evidence that Allan Ekberg is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the Mayor of the City of Tukwila to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this ____ day of _____, 2022.

_____
_____(Print Name)
Residing at _____
[Stamp or Seal] My appointment expires_____

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

I certify that I know or have satisfactory evidence that Deanna Dawson is the person who appeared before me, and said person acknowledged that she signed this instrument, on oath stated that she was authorized to execute the instrument and acknowledged it the Executive Director of Sound Cities Association to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this ____ day of _____, 2022.

_____
Notary Public for Washington

_____
(Printed or Stamped Name of Notary)
Residing at _____
[Stamp or Seal] My appointment expires: _____

CITY MANAGERS AND ADMINISTRATORS

Meeting Agenda
Wednesday, September 7, 2022
9:30 to 11:30 AM
HYBRID

In Person:
Tukwila Justice Center - 15005 Tukwila International Blvd, Tukwila, WA 98188
Note: Public Parking Lot is adjacent to Justice Center to the North, on South 150th

From Computer, Tablet, or Smartphone*:*
https://us02web.zoom.us/j/81538881020?pwd=SVc0S2wxQjN4c0lBR3ZFcU9MNEt4UT09
Dial in: (253) 215-8782 **Meeting ID**: 815 3888 1020 **Passcode**: 866144

9:30 AM A. Welcome and Introductions
David Cline, City Administrator, City of Tukwila

9:35 AM B. King County Drug Diversion Court
Christina Mason, Program Manager

10:00 AM C. Legislative Update – Association of Washington Cities
Candice Bock, Carl Schroeder and Sharon Swanson

10:20 AM D. Budget Roundtable – What are you planning?

10:40 AM E. WCMA Update
Kristi Rowland, WCMA President

10:50 AM F. SCA Update
Brian Parry, Interim Executive Director, Sound Cities Association (SCA)
Carl Cole, SeaTac City Manager, SCA Board Liaison

11:00 AM G. Adjourn

Sound Cities Association
2022 Legislative Agenda

SCA
SOUND CITIES ASSOCIATION
38 Cities. A Million People. One Voice.

Promote Economic Recovery

The COVID-19 public health crisis has had a devastating economic impact on Washington's businesses and workforce. Additional investments will be necessary to support long-term economic recovery. SCA urges the Legislature to:

* Provide tools and resources for local business recovery, particularly the small business community
* Be cognizant of tax implications and do no harm to individuals and businesses already hurt by the economic downturn

Address the Fiscal Needs of Cities to Provide Local Services

Cities play an essential role in providing basic core services to residents. SCA urges the Legislature to:

* Ensure that state-shared revenue distributions remain whole
* Provide greater flexibility with existing revenue sources
* Replace the 1% cap on annual property tax increases with a limit tied to inflation plus population growth
* Support local infrastructure funding and fully fund the Public Works Assistance Account

Law Enforcement Use of Force

Continue supporting local control over city law enforcement policies to meet the needs of each community, while recognizing the need for clarification of certain statewide reforms

Invest in Transportation Infrastructure & Mobility

The economic recovery and vitality of our state demands that we invest in our existing transportation infrastructure and prioritize new investments that improve the mobility of people and goods. SCA urges the Legislature to:

* Partner with cities to develop a comprehensive transportation revenue package that provides new resources and options for local governments to address multimodal transportation and mobility needs

Address Housing Instability

The state and cities must partner to preserve existing and increase the supply of affordable housing as well as address behavioral health needs and other root causes of homelessness. SCA urges the Legislature to:

* Address the instability resulting from the economic impacts of COVID-19 by increasing assistance to tenants, landlords, and homeowners as the statewide eviction moratorium ends
* Allocate federal funding to provide utility assistance to customers to satisfy past due accounts and avoid utility shutoffs
* Provide local option tools and incentives to diversify the housing supply what recognizes the diversity of our communities and maintains local decision-making authority

Legislative Guiding Principles

SCA adopts the following guiding principles through which all legislative proposals will be measured against:

*Advance racial equity and social justice
*Do not eliminate the social safety net
*No unfunded mandates to cities
*Preserve local decision-making authority
*Protect shared revenues

Sound Cities Association (WCIF)

Sound Cities Association (WCIF)
6300 Southcenter Blvd STE 206
Tukwila, WA 98188

Sound Cities Association (WCIF) FSA Plan

Plan Document

Amended and Restated January 01, 2023

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Sound Cities Association (WCIF) FSA Plan

INTRODUCTION

The company amends and restates this Plan as of January 01, 2023 with an original effective date of January 01, 2017. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the Sound Cities Association (WCIF) FSA Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

I. ARTICLE - PLAN DEFINITIONS

01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including but not limited to the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

02. **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".

03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

04. **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.

06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order shall be considered a Dependent under this Plan.

    "Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

    For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

    The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means January 01, 2017.

08. **"Election Period"** means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to the Article titled: "Participant Elections".

09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

    An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that

individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

    The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

11. **"Employer"** means Sound Cities Association (WCIF) and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.

12. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.

13. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.

14. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.

15. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

16. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.

17. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.

18. **"Plan Year"** means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

19. **"Premium Expenses"** or **"Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".

20. **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

21. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.

22. **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to the Section titled: "Salary Redirection". These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under the Article titled: "Participant Elections".

23. **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

24. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

II. ARTICLE - PARTICIPATION

01. **ELIGIBILITY**

An individual is eligible to participate in this Plan if the individual:

a. is an Eligible Employee as defined in the Article titled: "Definitions"
b. is working an average of 40 hours or more per week; and
c. is eligible for the group medical plan

02. **EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan.

03. **APPLICATION TO PARTICIPATE**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

04. **TERMINATION OF PARTICIPATION**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment"

b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death" or

c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

05. **TERMINATION OF EMPLOYMENT**

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

a. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

b. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for expenses within 60 days after the date of termination, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.

c. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.

06. **REINSTATEMENT OF A FORMER PARTICIPANT**

An Employee whose participation terminates and returns to an eligible status less than thirty days

later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into consideration so as not to exceed Plan or IRS maximums.

07. **DEATH**

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. SALARY REDIRECTION

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

02. APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

03. PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

04. EMPLOYER CONTRIBUTIONS

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

IV. ARTICLE - BENEFITS

01. **BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Term Life
- Long-Term Disability
- Group Medical Plan
- Group Dental Plan
- Accidental Death & Dismemberment
- Voluntary Benefit(s)

02. **HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

04. **HEALTH INSURANCE BENEFIT**

a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

05. **DENTAL INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

06. **GROUP TERM LIFE INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's group term life Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable group term life Insurance Contracts for use in providing this group term life insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group term life Insurance Contract shall be determined therefrom, and such group term life Insurance Contract shall be incorporated herein by

reference.

07. **LONG-TERM DISABILITY INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's long-term disability Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable long-term disability Insurance Contracts for use in providing this long-term disability insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such long-term disability Insurance Contract shall be determined therefrom, and such long-term disability Insurance Contract shall be incorporated herein by reference.

08. **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's accidental death and dismemberment Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment Insurance Contracts for use in providing this accidental death and dismemberment insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract shall be determined therefrom, and such accidental death and dismemberment Insurance Contract shall be incorporated herein by reference.

09. **VOLUNTARY BENEFIT(S)**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under a Voluntary Benefit Contract.

b. **Employer selects contracts.** The Employer may select suitable voluntary benefit Contracts for use in providing this voluntary benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such voluntary benefit Contract shall be determined therefrom, and such voluntary benefit Contract shall be incorporated herein by reference.

10. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

11. **NON-TAX DEPENDENT COVERAGE**

a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.

b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

V. ARTICLE - PARTICIPANT ELECTIONS

01. **INITIAL ELECTIONS**

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

02. **SUBSEQUENT ANNUAL ELECTIONS**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;

c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

03. **FAILURE TO ELECT**

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

04. **CHANGE IN STATUS**

a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in

status only if coverage for that individual ceases or is decreased under said other plan.

Regardless of the consistency requirement, if the individual, or the individual's Spouse or Dependent, becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

5. Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "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 (including a foster child who is a Dependent of the Participant):

   1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

   2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.

d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) 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). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under

the Plan if a benefit package option under the Plan provides similar coverage.

e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

   A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

g. **Addition of a new benefit.** Notwithstanding subsection (a), if, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.

j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

k. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in a Qualified Health Plan through a Marketplace that is effective no later than the day immediately following the effective date of the revocation.

l. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF BENEFIT

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below have the following meanings:

a. **"Health Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by the Participant, his or her Spouse and his or her Dependents may be reimbursed.

b. **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

   1. one of the 5 highest paid officers;

   2. a shareholder who owns (or is considered to own, applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

   3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

c. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

   A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

d. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

e. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

03. FORFEITURES

A Participant in the Health Care Flexible Spending Account may roll over up to $570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

04. LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is $2,850.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. The minimum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $120.00.

Carryover: A Participant in the Health Care Flexible Spending Account may roll over up to

$570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

05. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

06. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

b. **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.

c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 60 days after

the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 60 days after the date of termination.

08. **DEBIT AND CREDIT CARDS**

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Section titled: "Limitation on Allocations".

d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, including, but not limited to, the following:

   1. Co-payments for doctor and other medical care;

   2. Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

   3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.

f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.

g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

   1. Repayment of the improper amount by the Participant;

   2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;

   3. Claims substitution or offset of future claims until the amount is repaid; and

   4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

a. **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

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 Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;

2. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

1. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

2. a Dependent or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

04. **INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

05. **DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

06. **ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

07. **ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

08. **FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

09. **LIMITATION ON PAYMENTS**

a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000.00 (or cannot exceed $5,000 as provided under Code Section 129 or $2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

10. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).

b. **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of (i) the stock of, or (ii) the capital or profits interest in, the Employer.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination is prohibited by Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

11. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

12. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

a. The Dependent or Dependents for whom the services were performed;

b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;

c. The relationship, if any, of the person performing the services to the Participant;

d. If the services are being performed by a child of the Participant, the age of the child;

e. A statement as to where the services were performed;

f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

g. If the services were being performed in a day care center, a statement:

   1. that the day care center complies with all applicable laws and regulations of the state of residence,

   2. that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

   3. of the amount of fee paid to the provider.

h. If the Participant is married, a statement containing the following:

   1. the Spouse's salary or wages, if he or she is employed, or

   2. if the Participant's Spouse is not employed, that

      i. he or she is incapacitated, or

      ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.

i. **Claims for reimbursement.** If a Participant fails to submit a claim within 60 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ADMINISTRATION

01. PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

a. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

b. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

d. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such should be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

h. To establish and communicate procedures to determine whether a medical child support order is qualified; and

i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

02. EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to their interest under the Plan.

03. PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

04. **INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer or other benefit program that is self-insured whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

05. **INDEMNIFICATION OF ADMINISTRATOR**

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

IX. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

01. **AMENDMENT**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state and local laws, statutes and regulations.

02. **TERMINATION**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

X. ARTICLE - MISCELLANEOUS

01. **PLAN INTERPRETATION**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

02. **GENDER AND NUMBER**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

03. **WRITTEN DOCUMENT**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

04. **EXCLUSIVE BENEFIT**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

05. **PARTICIPANT'S RIGHTS**

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

06. **ACTION BY THE EMPLOYER**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by the Employer.

07. **EMPLOYER'S PROTECTIVE CLAUSES**

a. **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

b. **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

08. **NO GUARANTEE OF TAX CONSEQUENCES**

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

09. **INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant

as regular cash compensation, plus the Participant's share of any Social Security tax and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

10. **FUNDING**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11. **GOVERNING LAW**

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of Washington.

12. **SEVERABILITY**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

13. **CAPTIONS**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

14. **CONTINUATION OF COVERAGE (COBRA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

15. **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

16. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

17. **COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health

Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

   i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

   ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

   iii. mitigation of any harm caused by the breach, to the extent practicable; and

   iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:

1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

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

10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

18. **COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

a. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

b. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

c. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "Compliance with HIPAA Privacy Standards".

19. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

20. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

21. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Execution Agreement

IN WITNESS WHEREOF, Sound Cities Association (WCIF) has caused its authorized officer to execute this amended and restated Plan document as of _____, the same to be effective **January 01, 2023**, unless otherwise indicated herein.

Sound Cities Association (WCIF)

By: _____

Name: _____

Title: _____

CERTIFICATE OF RESOLUTION

The undersigned authorized representative of **Sound Cities Association (WCIF)** (the Employer) hereby certifies that the following resolutions were duly adopted by the governing body of the Employer on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended and restated Welfare Benefit Plan, effective January 01, 2023, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of Sound Cities Association (WCIF)'s Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

Sound Cities Association (WCIF)

By: _____

Name: _____

Title: _____

REHN & ASSOCIATES

Sound Cities Association (WCIF)

Sound Cities Association (WCIF)
6300 Southcenter Blvd STE 206
Tukwila, WA 98188

Sound Cities Association (WCIF) FSA Plan

Summary Plan Description

Amended and Restated January 01, 2023

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Sound Cities Association (WCIF)

Sound Cities Association (WCIF) FSA Plan

INTRODUCTION

The Company's Flexible Benefit Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

I. ARTICLE - ELIGIBILITY

01. **How can I participate in the Plan?**

    Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 40 or more hours per week and meet the eligibility requirements.

    After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

02. **What are the eligibility requirements for our Plan?**

    You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and the other eligibility requirements established by your employer as defined in section 1.

03. **When can I enter the plan?**

    You can enter the Plan on the same day you can enter our group medical plan.

04. **How do I enroll in the Plan?**

    Before you can join the Plan, you must complete an enrollment form. The enrollment form will allow you to select which benefits you want to participate in under the Plan. This form will also authorize the Company to redirect some of your earnings in order to pay for the benefits you select.

    However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan. These benefits are listed in the Article titled: "Benefits".

II. ARTICLE - OPERATION

01. **How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

III. ARTICLE - CONTRIBUTIONS; ELECTIONS

01. **How much of my pay may the Employer redirect?**

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

02. **What happens to contributions made to the Plan?**

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

03. **When must I decide which accounts I want to use?**

You are required by Federal regulations to decide during the enrollment or election period (defined below) prior to the Plan Year start. You must decide which accounts you want and how much you want to contribute to each account.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance, unless you elect during the election period (defined below) not to participate in the Plan.

04. **When is the election period for our Plan?**

You will make your initial election on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Company and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Company will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

05. **May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the

law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse, former spouse or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

06. **May I make new elections in future Plan Years?**

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Company will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV. ARTICLE - BENEFITS

01. **What benefits are offered under the Plan?**

You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

02. **Health Flexible Spending Account**

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by our insured medical plan, and to save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account for the Plan Year is $2,850.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. The minimum amount you contribute for the Plan Year is $120.00. In addition, you may carry over any amount left in your account up to $570.00. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. This amount can be used the following Plan year to pay for eligible expenses.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified medical expenses. The Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A “child” is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status for purposes of coverage changes.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

03. **Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is $5,000.00. The minimum amount you can contribute to the Dependent Care Flexible Spending Account for the plan year is $120.00.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than

six individuals, the facility complies with applicable state and local laws;

b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000.00 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed annual earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

04. **Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various group insurance programs the Company offers you. These premium expenses include:

- Health care premiums under our insured group medical plan
- Dental insurance premiums
- Group term life premiums (up to $50,000 maximum benefit)
- Long-term disability insurance premiums
- Accidental death and dismemberment insurance premiums
- Voluntary Benefit(s)

Under this Plan, the Company will allocate the pre-tax premium withholding to the accounts established under the Plan pursuant to the Participants' elections. Certain limits on the amount of coverage that can be paid through pre-tax premiums may apply.

The Company may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. The Company will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V. ARTICLE - BENEFIT PAYMENTS

01. **When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Health Flexible Spending Account or Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

02. **What happens if I don't spend all Plan contributions during the Plan Year?**

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the Employer. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited.

At the end of the Plan Year, and after all eligible reimbursements have been made, any unused funds up to $570.00 in your Health Flexible Spending Account will roll over into the new Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. Any unused funds left in the account in excess of maximum limit will be forfeited. For the Health Flexible Spending Account, you must submit claims no later than 60 days after the end of the Plan Year.

For the Dependent Care Flexible Spending Account, you must submit claims no later than 60 days after the end of the Plan Year.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

03. **Family and Medical Leave Act (FMLA)**

If you take a leave under the Family and Medical Leave Act, you may continue, revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage for these benefits terminates, due to your revocation of the benefit to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference – for example, from $100 per month to $150 per month, etc. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

04. **What happens if my employment terminates?**

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

a. You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

b. You will still be able to request reimbursement for qualifying dependent care expenses up to 60 days after the date of termination from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.

c. For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA."

Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 60 days after the date of termination, claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

05. **Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Company contributions to Social Security on your behalf.

VI. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

01. **Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII. ARTICLE - PLAN ACCOUNTING

01. **Periodic Statements**

Periodically during the Plan Year, the Administrator will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

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

01. **General Plan Information**

Sound Cities Association (WCIF) FSA Plan is the name of the Plan.

Your Employer has assigned Plan Number 510 to your Plan.

The company amends and restates this Plan as of January 01, 2023 with an original effective date of January 01, 2017.

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

02. **Employer Information**

Your Employer's name, address, and tax identification number are:

Sound Cities Association (WCIF)
Leah Willoughby
6300 Southcenter Blvd STE 206
Tukwila, WA 98188
206-849-8132
leah@soundcities.org
FEIN: 91-1616272

03. **Plan Administrator Information**

The name and address of your Plan's Administrator are:

Sound Cities Association (WCIF)
6300 Southcenter Blvd STE 206
Tukwila, WA 98188
206-849-8132
leah@soundcities.org

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

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan. The Plan's Agent of Service is:

Sound Cities Association (WCIF)
6300 Southcenter Blvd STE 206
Tukwila, WA 98188
206-849-8132
leah@soundcities.org

05. **Type of Administration**

The type of Administration is Employer Administration.

06. **Claims Submission**

Claims for expenses should be submitted to:

Sound Cities Association (WCIF)
6300 Southcenter Blvd STE 206
Tukwila, WA 98188
206-849-8132
leah@soundcities.org

IX. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") beyond the time when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

01. **What is COBRA continuation coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

02. **Who can become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

03. **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provides that the Plan participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

a. The death of a covered Employee.

b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

c. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

d. A covered Employee's enrollment in any part of the Medicare program.

e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

04. **What factors should be considered when determining to elect COBRA continuation coverage?**

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should be aware that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

05. **What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

06. **What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

07. **Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

a. the end of employment or reduction of hours of employment,

b. death of the employee,

c. commencement of a proceeding in bankruptcy with respect to the Employer, or

d. entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES: Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Rehn and Associates

PO Box 5433
Spokane, WA 99205

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

08. **Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

09. **Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. **When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

a. The last day of the applicable maximum coverage period.

b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

c. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

e. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

f. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

1. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. **What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

b. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

c. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

d. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. **Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of

the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. **How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. **Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. **Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

16. **What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

18. **Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

19. **How is my participation in the Health Flexible Spending Account affected?**

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money

than you have taken out in claims. For example, if you elected to contribute an annual amount of $750 and, at the time you terminate employment, you have contributed $400 but only claimed $200, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $750. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Attachment A

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our

privacy practices, contact the person listed below:

Sound Cities Association (WCIF)
Leah Willoughby
6300 Southcenter Blvd STE 206
Tukwila, WA 98188
206-849-8132
leah@soundcities.org

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

SOUND CITIES ASSOCIATION

38 Cities. A Million People. One Voice.

SCA Board and Staff Commitments – Values to Focus on for 2022

- Angela Birney:
  - 2022 focused value: Growth
  - Commitment: Grow engagement with newly elected officials and other SCA members
- Bill Boyce:
  - 2022 focused value: Service
  - Commitment: Be present as a leader, help newer members understand the role and responsibilities of SCA
- Traci Buxton:
  - 2022 focused value: Contribution
  - Commitment: Amplify voices that are not being heard
- Carl Cole:
  - 2022 focused value: Growth
  - Commitment: Learn more about SCA, find out how I can be a resource to the elected officials
- Deanna Dawson:
  - 2022 focused value: Contribution
  - Commitment: Devote at least 4 hours per week to big picture - how the work of SCA matters, how to move the organization forward
- Jim Ferrell:
  - 2022 focused value: Gratitude
  - Commitment: Express gratitude for being on board by being fully present and participatory in meetings
- Kazia Mermel:
  - 2022 focused value: Purpose
  - Commitment: Take time to reflect on how my purpose is aligned with my work
- Jan Molinaro:
  - 2022 focused value: Health
  - Commitment: Set attainable commitment on physical health, get out and do it
- Amy Ockerlander:
  - 2022 focused value: Growth
  - Commitment: Connect with newer elected officials in Snoqualmie Valley, offer mentorship
- Brian Parry:
  - 2022 focused value: Compassion

    - Commitment: Recognize the challenges and perspectives of others, provide support to members
- Mary Lou Pauly:
    - 2022 focused value: Service
    - Commitment: Help plan an SCA event with an equity focus, help plan an SCA event with a focus on civility
- De'Sean Quinn:
    - 2022 focused value: Contribution
    - Bring my full self and perspective to the table, share my lived experience, be candid and call out when we need to refocus on outcomes
- Jeff Wagner:
    - 2022 focused value: Hope
    - Commitment: Maintain positive and optimistic outlook, raise over $100 K revenue
- Wendy Weiker:
    - 2022 focused value: Health
    - Commitment: Address the long term health of SCA by committing to reach out to 15 members and discuss why regionalism and SCA are important
- Hali Willis:
    - 2022 focused value: Fun
    - Commitment: Laugh or make someone laugh in at least one meeting per week
- Leah Willoughby:
    - 2022 focused value: Humor
    - Commitment: Plan three fun staff get togethers for 2022
- James McNeal
    - Focus value: Regional Equity
    - Commitment: Meeting leaders in their cities to better understand their issues and how we are connected. Refocus MELO Find solutions and have discussion on what it means to listen and learn focus on working together.
- Ed Prince
    - Focus value:
    - Commitment: