COUNTY OF SANTA BARBARA

FLEXIBLE BENEFITS PLAN

I.R.S. SECTION 125 PLAN

Effective May 1, 1989

Revised December 1, 2005

Revised & Effective July 1, 2006

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EMPLOYEE BENEFIT PLAN

Effective as of May 1, 1989, the County of Santa Barbara adopted the Section 125 Plan (hereinafter "Plan"), under Internal Revenue Code § 125 to provide benefits for certain of its employees. The purpose of this Plan is to allow Employees of the Employer to choose between certain Benefits provided by the Employer or additional cash compensation so that Employees may receive Benefits that best meet their individual needs. The Employer intends that the Plan qualify as a "cafeteria plan" with the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended, and that the Qualified Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for Federal Income Tax purposes. The Employer may offer a choice among additional benefits that may not constitute Qualified Benefits, but nothing in this Plan shall be construed' as offering any taxable benefits except to the extent that the Employer may otherwise specifically provide.

This Plan incorporates the insured and self-insured medical and dental plans covering Eligible Employees of the County of Santa Barbara, any current service contracts the County of Santa Barbara has with Health Maintenance Organizations, and any other plans listed in Schedule A, as amended, of this Plan.

The provisions of this Plan shall apply only to any regular full-time, or part-time employee who is eligible to receive benefits under at least one of the Component Plans listed in Schedule A. The rights to benefits, if any, of former employees will be determined in accordance with provisions of the Plan in effect on the date employment terminated.

Schedules A & B (Component Plans) attached to this Plan are incorporated herein by reference and are a part hereof, and may be amended without necessity for other amendment of this Plan. This Plan is revised as of January 1, 2005.

ARTICLE I

DEFINITIONS

When used in this Plan, the following words and phrases shall have the following meanings unless the context clearly indicates otherwise:

1.1 Affiliated Employer

Any public agency that is included with the Employer by resolution or agreement adopted by both parties for the purpose of participation in the Flexible Benefits Plan

1.2 Applicable Law

The Code as herein defined, or any other law of the United States or any state or political subdivision thereof which may apply to this Plan.

1.3 Benefits

Benefits means any benefit offered by a Component Plan.

1.4 Change in Status

A. a change in the Eligible Employee's legal marital status, such as marriage, divorce, annulment, legal separation or death of Spouse;

B. a change in the Eligible Employee's number of Dependents, such as birth, death, adoption or placement for adoption of a Dependent;

C. a change in employment status (e.g., commencement or termination of employment) of the Eligible Employee, the Eligible Employee's Spouse or the Eligible Employee's Dependent;

D. a reduction or increase in hours of employment by the Eligible Employee, the Eligible Employee's Spouse or the Eligible Employee's Dependent, including a switch between part-time and full-time status, a strike or lockout, or commencement or return from an unpaid leave of absence;

E. an event that causes the Eligible Employee's Dependent to satisfy or cease to satisfy the requirements for coverage under the Program;

F. a change in the place of residence or work of the Eligible Employee, the Eligible Employee's Spouse or the Eligible Employee's Dependent; and

G. a situation where the Eligible Employee, the Eligible Employee's Spouse or the Eligible Employee's Dependent has special enrollment rights under the Health Insurance Portability and Accountability Act of 1996.

1.5 Child

A child is any of the employee's or retiree's unmarried children, including natural children, stepchildren, foster children placed with the employee or retiree by an authorized agency or by court order, and children who, before reaching the age of 18, are either adopted by the employee or retiree or placed in the employee's or retiree's home for adoption.

1.6 Code

The Internal Revenue Code of 1986, as amended, as it now exists or from time to time may be amended.

1.7 Compensation

The total earned income, salary, wages, overtime, and all other earnings of a Participant, reportable on Form W-2 for the Plan Year, including amounts contributed by an Employee to the Plan, but excluding all other contributions to any other plan sponsored by the Employer, and all other forms of compensation.

1.8 Compensation Reduction Agreement

A voluntary agreement whereby an Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year), for purposes of obtaining the Qualified Benefits offered by the Plan.

1.9 Compensation Reduction Credits

The dollar amount set aside for Benefits under Section 4.1 and credited to the Participant's Spending Account(s).

1.10 Component Plan

A separate written plan maintained by the Employer to provide medical, hospital, dental, accident or life insurance, or dependent care assistance to employees. Such Component Plans are listed in Appendix A, which may be amended at any time without necessity for other amendment of this Plan. Each Component Plan is governed by the terms of its plan document, which terms shall prevail in case of any conflict between this Plan and a Component Plan.

1.11 Dependent

Any individual who is a dependent of an Eligible Employee as defined in a Component Plan under which the Eligible Employee has a benefit entitlement.

1.12 Effective Date

May 1, 1989, the date on which this Plan became effective.

1.13 Eligible Employee

Any full-time, part-time regular employee of the Employer who is eligible to receive benefits under at least one of the Component Plans. Any person who is covered by a collective bargaining agreement which does not provide for inclusion in this Plan shall not be an Eligible Employee. Any person who performs service for the Employer solely as an independent contractor or extra-help employee shall not be an Eligible Employee.

1.14 Regular Employee

Any employee who fills a position in the classified service of the County or is an elected official of the County.

1.15 Eligible Expense

Any premiums Eligible Employees must pay for themselves or for Dependents for coverage under a Component Plan; medical care expenses (within the meaning of Code Section 213) paid by Eligible Employees for themselves or for Dependents, which are not reimbursed or paid under any applicable group insurance policy; dependent care expenses eligible for reimbursement under the County of Santa Barbara Dependent Care Assistance Program. Eligible Expenses are detailed in Article IV.

1.16 Employer

County of Santa Barbara, and any Affiliated Employer.

1.17 Enrollment Period

The period designated by the Employer each year for the purpose of enrolling Employees into the Plan.

1.18 ERISA

The Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

1.19 Highly Compensated Employee (HCE)

Any employee defined as such in Section 414(q) of the Code.

1.20 Key Employee

Any employee defined as such in Code Section 416(i)(l).

1.21 Participant

An Eligible Employee who participates in the Plan pursuant to Article II, or a former Eligible Employee who participated in the Plan during the current Plan Year and who had an amount greater than zero credited to his or her account when (s)he ceased to be an Eligible Employee.

1.22 Plan

The County of Santa Barbara Flexible Benefits Plan (also referred to as the Section 125 Plan), the terms of which are set forth herein, as it may be amended from time to time.

1.23 Plan Administrator

The Employer, notwithstanding the fact that certain administrative functions for this Plan may be delegated to a committee or to any other person, persons, or entity.

1.24 Plan Year

Each twelve-month period commencing on January 1 and ending on December 31. Records of the Plan shall be established and maintained on the basis of the Plan Year.

1.25 Qualified Benefits

Each Benefit described in Code Section 125(f) and the regulations promulgated thereunder.

1.26 Spending Account(s)

The account(s) established as provided under Section 3.1 in the Participant's name and which is used to record the allocation of Compensation Reduction Credits and their expenditure for Qualified Benefits.

ARTICLE II
ELIGIBILITY AND PLAN PARTICIPATION

2.1 Eligibility

Eligible Employees shall become eligible to participate in the Plan on the first day of the pay period on or after the date of hire provided that the employee is covered under at least one of the Component Plans. Eligible Employees have 30 days from the date of hire to enroll in the Plan.

2.2 Conditions of Participation

Participation in this Plan by an Eligible Employee shall be contingent upon participation in a Component Plan and upon receipt by the Plan Administrator of such applications, consents, proofs of birth or marriage, elections, beneficiary designations, proof of reimbursable expenses and other documents and information as may be prescribed by the Plan Administrator. Each Eligible Employee upon becoming covered by the Plan shall be deemed conclusively, for all purposes, to have assented to the terms and provisions of this Plan and shall be bound thereby.

2.3 Termination of Participation

Participation in this Plan shall terminate as of the earlier of:

A. the date on which the Plan terminates;

B. the date on which he ceases to be an Eligible Employee; or

C. the date on which he fails to make a contribution required under the terms of the Plan.

Nothing in this Section 2.3 shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation.

Notwithstanding the foregoing, a former Participant who continues to receive Compensation from the Employer shall remain a Participant for all purposes until such Compensation ceases.

2.4 Recommencement of Participation

If a Participant terminates employment and resumes employment within thirty (30) days, the Participant's elections prior to termination of employment shall be automatically reinstated, subject to any intervening Change in Status. If a former Participant resumes employment more than thirty (30) days after an earlier termination of employment, the former Participant may return to the elections in place prior to termination of employment or make new elections.

2.5 FMLA Leave

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") or elects to substitute accrued paid leave for unpaid FMLA Leave may revoke his or her election to participate under any group health plan coverage (including the Health Care Reimbursement Account) offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation

shall be effected in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

ARTICLE III
PLAN FUNDING

3.1 Funding

The Benefits provided herein shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of Compensation as a Participant elects to forego pursuant to a Compensation Reduction Agreement.

3.2 Execution of Agreements

Prior to the beginning of the Plan Year, the Administrator shall provide a written election form, which shall include a Compensation Reduction Agreement to each Participant and to each other Employee who is expected to become an Eligible Employee by the first day of the Plan Year. All Compensation Reduction Agreements entered into by Participants in the Plan shall be executed before the beginning of the Plan Year for which such agreements will be effective or, in the case of Participants who were not eligible to participate in the Plan at the beginning of the Plan Year, within 30 days after an employee becomes an Eligible Employee under the Plan. Each Compensation Reduction Agreement shall remain effective throughout the Plan Year unless revoked or suspended by reason of any Participant's ceasing to be an Eligible Employee. No Compensation Reduction Agreement may be revoked by any Participant during the Plan Year for which it is effective, except pursuant to Article IV. Any Participant who fails to execute appropriate agreements during the Enrollment Period shall be deemed to have elected to maintain his prior Plan Year's elections except that the Participant will not be eligible for either Spending Account. Any newly Eligible Employee who fails to execute appropriate agreements during the Enrollment Period to become a Participant shall be deemed to have elected cash Compensation to the extent permissible.

3.3 Amount of Compensation Reduction

The Compensation reduction amount shall be specified by the Eligible Employee in the Compensation Reduction Agreement. Such Compensation reduction shall not exceed the amount set forth on Schedule B. attached hereto. The Compensation reduction amount shall be designated on a per pay period basis.

3.4 Crediting of Compensation Reduction Amounts

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

Absent a request otherwise, each Eligible Employee will be deemed to have made a written Compensation reduction election to have his or her annual compensation reduced by the amount such employee is required to pay as a condition for coverage under the County medical and dental Component Plan(s) and Life and Accident Insurance Plans in which

Employees and Dependents are enrolled. The amount of this Compensation Reduction will be credited to the Participant until it is paid out for such coverage. In the event an Eligible Employee requests to not participate in this Plan, (s)he shall receive his or her Compensation without any reduction for this Plan and will be required to pay any required Component Plan contribution through payroll withholding.

ARTICLE IV

BENEFITS

4.1 Compensation Reduction Credits

There shall be credited to each Participant's Spending Account(s) those Compensation Reduction Credits that correspond to the Participant's Compensation Reduction amount under Section 3.3. Such contributions shall not exceed the amounts set forth on Schedule B attached hereto, as revised by the Employer from time to time. The Participant's Compensation Reduction Credits shall be credited when the Participant's Compensation is reduced, pursuant to the Compensation Reduction Agreement then in effect. The Compensation Reduction Credits shall be allocated in accordance with the Benefits the Participant has designated pursuant to Section 4.2. The amount of Benefits actually provided to or for the benefit of any Participant shall be a charge to the balance of his Spending Account(s).

4.2 Election of Benefits

Each Eligible Employee shall submit to the Employer before the close of the Enrollment Period for each Plan Year, a written statement identifying the Benefits to be provided by the Employer to the Eligible Employee, and the portion of the Eligible Employee's anticipated Compensation Reduction Credits for the Plan Year which may be applied to provide each Benefit. If the Participant's Compensation Reduction Credits actually exceed the sum of amounts allocated to provide Qualified Benefits available under the Plan, the Participant shall be deemed to have allocated such excess to the provision of additional cash Compensation. Each election under this Section 4.2 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Code Section 125.

4.3 Nature of Participant Spending Account(s)

No money shall actually be allocated to any Spending Account(s); any such Spending Account(s) shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes and shall not be representative of any identifiable Trust assets. No interest will be credited to or paid on amounts credited to a Spending Account(s).

4.4 Provision of Benefits

The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount allocated to the provision of each such Benefit pursuant to this Section 4.4 and subject to Employee Contributions, if any, pursuant to Section 4.13. Such Benefits shall be subject to the provisions of any plan, contract or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided. Any condition or restriction imposed by an insurance company providing any Benefit and the terms of each Employer plan under which Benefits are provided are incorporated by reference in this Plan. To the extent the Participant has elected to receive additional cash Compensation (or is deemed to have made such an election), such Compensation shall be paid pursuant to this Section 4.4.

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

Notwithstanding the foregoing, the maximum amount of reimbursement under the Health Care Reimbursement Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treas. Reg. §1.125-2, Q&A-7(b)(2).

4.5 Revocation and Modification of Elections.

A. Change in Status

If an Employee or his or her Dependent incurs a Change in Status, the Employee may change or revoke his or her elections during the Plan Year and make a new election for the remaining portion of the Plan Year if the revocation and new election are on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan or a similar plan of the Employee's Dependent. A Change in Status that affects eligibility under an employer's plan includes a Change in Status that results in an increase or decrease in the number of an Employee's family members or dependents who may benefit from coverage under the Plan. With respect to group term life insurance coverage, an election under the Plan to increase or decrease coverage in response to a Change in Status shall be deemed to correspond with that Change in Status. The Plan Administrator has the sole discretionary authority to determine whether the Change in Status consistency requirement has been met. Any determination by the Plan Administrator shall be final and binding. An election change or revocation made on account of birth, adoption or placement for adoption under this subsection 4.5 within the 31-day period following such event shall be effective as of the date of the birth, adoption or placement for adoption, provided such change complies with any rules or requirements under the applicable Plan. All other election changes made within 31 days of a Change in Status shall be effective as soon as practicable once the request for such election change has been received. Changes to an Eligible Employee's Compensation Reduction Agreement may not be made more than 31 days following the Change in Status event that relates to the request to change the Employee's elections.

B. Other Election Changes

In addition to any other changes in coverage made under the Plan, an Employee may change his or her election of coverage during the Plan Year under the following circumstances if permitted in accordance with the terms and provisions of the Plan:

(1) If an Employee is subject to a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order under ERISA §609) that requires coverage under a Plan for the Employee's Child, the Employee shall be required to change his or her election (including the Employee's enrollment in the Plan, if not previously enrolled) to provide coverage for such child. If the Employee is subject to a judgment, decree or order resulting from divorce, legal separation, annulment

or change in legal custody (including a qualified medical child support order under ERISA §609) that requires coverage of a child under the plan of the Employee's spouse, former spouse or other individual, an Employee shall not be allowed to drop coverage for such child unless the other coverage is, in fact, provided.

(2) If an Employee and/or his or her Dependent becomes entitled to coverage (i.e., enrolled) under Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act), the Employee may revoke his or her coverage under the applicable Plan and that of his or her Dependents. In addition, if an Employee and/or his or her Dependent lose entitlement to coverage under Medicare or Medicaid, the Employee may elect to commence coverage for that affected individual.

C. Significant Cost and Coverage Changes

The provisions of this subsection C shall not apply to the Health Care Reimbursement Account Plan.

Significant Cost Changes: If the cost of a benefit option significantly increases or decreases during the Plan Year, a corresponding prospective increase or decrease will automatically be made to the Employee's elections under the Plan. If the cost of a benefit option significantly increases during the Plan Year, the Employee may revoke his/her elections and make a new election on a prospective basis for coverage under another option providing similar coverage, or if no such similar option is available, the Employee may drop coverage under the Plan.

Significant Cost Decreases: If the Plan Administrator determines that the cost of any benefit package option that may be elected under this Cafeteria Plan (other than the Health Care Reimbursement Account) significantly decreases during a Plan Year, then the Plan Administrator may permit Participants who are enrolled in a benefit package option (e.g. an HMO) other than the benefit option that has decreased in cost, to change their election on a prospective basis to elect the benefit package option that has decreased in cost. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

Significant Coverage Changes: If a Participant's coverage under a benefit option is significantly curtailed or ceases during a Plan Year, the Employee may make a new election on a prospective basis for coverage under another benefit option providing similar coverage. For this purpose, coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants generally. If a Participant's coverage under a benefit option is significantly curtailed during the Plan Year so as to result in a loss of coverage for the Participant, an Employee may revoke his or her election under the Plan and elect either to receive on a prospective basis coverage under another option providing similar coverage or drop coverage if no similar coverage is available. For purposes of this subsection (ii), examples of a "loss of coverage" shall include the elimination of a benefit option, an HMO ceasing to be available in the area where the individual resides, the attainment of an overall lifetime or annual

limitation, a substantial decrease in the medical care providers available under an option, a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant is currently in the course of treatment and any other similar fundamental loss of coverage.

Addition, Improvement or Elimination of Benefit Option: If a benefit option under a Plan is added or significantly improved during a Plan Year, each affected Employee (whether or not previously enrolled) may elect the newly added option, or may elect another option if an option has been eliminated, on a prospective basis.

Change in Dependent's Coverage Under Another Employer's Plan: If a cafeteria plan or a qualified benefits plan of a Dependent permits election changes under rules that comply with Code Section 125 and the regulations thereunder, or if such plan permits participants to make election changes for a period of coverage that differs from the Plan Year under the Plan, the Employee may make a new election for coverage under the Plan for the remainder of the Plan Year, provided such election is on account of and corresponds with a change made under the plan of the Employee's Dependent.

4.6 Cash Payments

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

4.7 Forfeitures.

If the total Qualified Benefits paid or reimbursed to a Participant with respect to any Plan Year are less than the Compensation Reduction Credits allocated to the provision of such Qualified Benefits, the unused portion shall be forfeited three months after the end of the Plan Year. No Participant shall be entitled to carry over any unused Qualified Benefits to the succeeding Plan Year, or to reallocate the unused portion to any other Benefit, nor shall any Participant be entitled to receive any unused Qualified Benefits in the form of additional cash.

4.8 Reimbursements.

Except as otherwise provided in any plan, contract or arrangement established to provide Benefits, reimbursement of Expenses shall be made at such time and in such amounts as shall be determined by the Employer in accordance with Treas. Reg. §1.125-2 Q&A-7(b)(2). The amount credited to the Participant's Spending Account(s) for any Plan Year shall be used only to reimburse the Participant for Qualified Benefits incurred for such Plan Year, and only if the Participant applies for reimbursement on or before June 15 following the close of the Plan Year. In addition, amounts credited to a Participant's Spending Account(s) may be used to reimburse certain expenses incurred during a Grace Period that immediately follows the Plan Year to the extent allowed by the Health Care Reimbursement Account and the Dependent Care Reimbursement Account Plans. Claims for reimbursement of expenses incurred during the Grace Period must be submitted no later than June 15 following the close of the Plan Year to which the Grace Period relates.

4.9 Nondiscrimination.

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

4.10 Insurance Contracts

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

4.11 Benefit Costs

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

4.12 Termination of Employment

If an Eligible Employee separates from service with the Employer during a period in which he is covered under the Plan, the Employer may terminate the remaining portion of Benefits provided by the Plan. A separated Employee shall be entitled to reimbursement for claims for Qualified Benefits incurred prior to his separation of employment, only if the Employee (or his estate) applies for such reimbursement on or before June 15 following the end of the Plan Year. In addition, a separated Employee may be reimbursed for certain expenses incurred prior to separation and during a Grace Period that occurs prior to separation. Claims for reimbursement of expenses incurred during the Grace Period must be submitted no later than June 15 following the close of the Plan Year to which the Grace Period relates.

4.13 Employee Contributions

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

4.14 Payment of Contributions While on FMLA Leave

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and who elects to continue participation under this Plan shall be responsible for making the required contributions under the group health insurance plan and Health Care Reimbursement Account offered under this Plan during the period of the

FMLA Leave. The manner in which such payments are made as determined by the Plan Administrator in its sole discretion, is as follows:

Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant. Coverage under the group health and health care spending account plans shall cease if payments are over 30 days late provided the Participant is first given written notice of the delinquency indicating that coverage will cease if payment is not received on a specified date at least 15 days after the date of the notice. The cancellation date will be retroactive as of the last covered date for which the employee paid. If coverage lapses because the Participant fails to make the required payments, coverage shall be restored upon the Participant's return from FMLA Leave.

When a Participant elects to substitute accrued paid leave for unpaid FMLA Leave and elects to continue participation under this Plan (including the Health Care Reimbursement Account) during such leave, the Participant's Compensation Reduction Agreement must continue on the same terms that applied prior to taking such leave.

4.15 Uniformed Service Under USERRA

A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in this Plan (including the Health Care Reimbursement Account). Participants who are absent from employment for fewer than 31 days may continue coverage under this Plan (including the Health Care Reimbursement Account) provided employee contributions are made for the period of "uniformed service." The coverage period may be continued for the period of the Participant's service in the uniformed services provided the Participant pays the required contribution toward the cost of the coverage during the leave. The Participant shall be responsible for making the required contributions during the period which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 4.14 (regarding the payment of contributions with respect to FMLA Leave). A Participant whose coverage under the group health insurance plan and/or the medical savings account portion of the Plan is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

ARTICLE V

PLAN ADMINISTRATION

5.1 Allocation of Plan Administration Responsibilities

A. The Employer shall be responsible for the general administration of the Plan and each component Plan thereunder. The powers and duties of the Employer shall include (without limitation):

(i) Determination of questions arising under the Plan, of the rights or eligibility of employees under any Component Plan forming a part of the Plan, and the amounts of their benefits;

(ii) Adoption of such procedures and regulations as in the Employer's opinion is necessary for the proper and efficient administration of the Plan and is consistent with the terms and purposes of the Plan;

(iii) Enforcement of the Plan according to its terms and to the rules and regulations adopted by the Employer.

B. The Employer may delegate to other organizations or persons (who also may be employees) specific fiduciary responsibilities of the Employer in administering this Plan. Fiduciary duties which may be delegated include (without limitation):

(i) The responsibility to administer and manage any Component Plan which forms a part of the Plan;

(ii) The responsibility to prepare, report, file and disclose any forms, documents and other information required by law to be reported or filed with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and

(iii) The responsibility to review claims or claims denials under one or more of the Component Plans under the Plan.

5.2 Rules of Administration

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

5.3 Discretionary Power of Plan Administrator

All discretion conferred upon the Plan Administrator will be absolute. However, no discretionary power conferred on the Plan Administrator will be exercised in a manner that causes discrimination in favor of Highly Compensated Employees. The discretionary

power of the Plan Administrator will be exercised in a non-discriminatory manner with regard to all similarly situated employees or Participants.

5.4 Services to the Plan.

The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the provisions of the Plan. The costs of such services and other administrative expenses shall be paid by the Employer.

5.5 Funding Policy.

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

5.6 Claims Procedure

The Plan Administrator, or their designee, shall notify each Eligible Employee of his or her entitlement to receive benefits under this Plan and shall provide appropriate forms on which application for such benefits may be made.

Each Eligible Employee claiming a benefit under the Plan must complete and file such application forms with the Plan Administrator. The Plan Administrator shall review all applications for benefits. It shall notify the claimant in writing of its decision within sixty (60) days of receipt of the application. If special circumstances require any extension of time (not to exceed ninety (90) days) for processing the claim, the Plan Administrator must notify the claimant in writing of the extension prior to the expiration of the initial sixty (60) day period.

Any denial by the Plan Administrator of a claim for benefits shall be stated in writing and delivered to the Eligible Employee. The notice shall state clearly in language calculated to be understood by the Eligible Employee without legal counsel:

A. the specific reason(s) for the Administrator's decision,

B. what additional material or information the Participant must provide so the Plan Administrator will reconsider the claim or pay the premiums from the Participant's account; and

C. the Plan's appeals procedures.

5.7 Appeal and Review Procedure

If a claim has been denied by the Plan Administrator, the claimant may appeal the denial within sixty (60) days after receipt of written notice thereof by submitting in writing to the Plan Administrator a request for review of the denial of claim. A claimant also may submit a written statement of issues and comments concerning the claim and may request an opportunity to review the Plan, any Component plan, and any other pertinent documents. If so requested, the Plan Administrator shall make these available to the claimant within thirty

(30) days after its receipt of a copy of the request, at a convenient location during regular business hours.

If a claimant appeals, the Plan Administrator shall render its final decision, the specific reasons therefore in writing, and transmit it to the claimant by certified mail within (60) days of its receipt of the request of review. If special circumstances require an extension of time, written notice of the extension shall be given to the Participant before the end of the original 60-day period, and a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review.

5.8 Agent for Service of Process

The agent for service of process for the Plan shall be the person currently listed as the Plan Administrator.

5.9 Notices

Notices and documents relating to the Plan may be delivered, or mailed by registered mail, postage prepaid, to the Human Resources Director, County of Santa Barbara, 1226 Anacapa Street, Santa Barbara, California 93101. Any notice required under the Plan may be waived by the person entitled to notice.

5.10 Evidence

Evidence required of anyone under the Plan may be by certificate, affidavit, document or other information which the person acting on it considers pertinent and reliable. The evidence may be signed, made or presented by the proper party or parties.

5.11 Nondiscriminatory Operation.

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

5.12 Liability of Administrative Personnel.

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

ARTICLE VI

CONTINUATION OF COVERAGE

6.1 In General.

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

6.2 Continuation of Coverage.

To the extent required by Section 6.1 above, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

6.3 Type of Coverage.

Continuation coverage under this provision is coverage that is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

6.4 Coverage Period.

The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the

Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event;

C. in the case of a qualifying event (other than the covered Employee becoming entitled to benefits under Medicare) which occurs during the 18 months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, for the covered dependents, the date which is 36 months after the date that a covered Employee is terminated (except for gross misconduct), or the date that a covered Employee's hours are reduced;

D. (i) for plan years commencing on or prior to June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered Employee and that Employee's subsequent entitlement to Medicare while continuation coverage is in force for the qualified beneficiary, the date which is 36 months after the date of the covered Employee's entitlement to Medicare;

(ii) for plan years commencing after June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered employee that occurs less than 18 months after the covered employee becomes subject to Medicare, for the covered dependents, the date which is the close of the 36-month period beginning on the date the covered employee became entitled to Medicare.

E. in the case of any qualifying event except as described in A., B., C. and D. above, the date which is 36 months after the date of the qualifying event;

F. the date on which County of Santa Barbara or a Participating Employer ceases to provide any group health plan to any Employee;

G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision; and

H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth in this Section 6.4.

6.5 Contribution.

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by County of Santa Barbara in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments.

B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

6.6 Notification by Qualified Beneficiary.

Each covered Employee or qualified beneficiary must notify County of Santa Barbara of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph that occur after the date of the enactment of the Tax Reform Act of 1986.

6.7 Notification to Qualified Beneficiary.

A. County of Santa Barbara shall provide written notice to each covered Employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

B. County of Santa Barbara shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, County of Santa Barbara shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies County of Santa Barbara of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

C. Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

6.8 Definitions. The following terms used in the text of this Section 6 are defined as follows:

A. "Dependents" means an individual who meets the definition of dependent under the Participating Employer provided health plan covering the Eligible Employee.

For the purposes of the Health Care Reimbursement Plan, dependents will also include individuals who are dependents within the meaning of Section 1.1 of the Health Care Reimbursement Plan.

No person shall be considered a dependent of more than one Employee.

If both an Employee and an Employee's spouse are employed by County of Santa Barbara, dependent children may be covered by either spouse, but not by both.

B. "Election Period" means the 60-day period during which a qualified beneficiary who "would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

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

D. "Qualified Beneficiary" means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the spouse or dependent child of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term qualified beneficiary includes the covered Employee. A child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary.

Exception — the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and Section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

E. "Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

(i) the death of the covered Employee;
(ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered employee's employment;
(iii) the divorce or legal separation of the covered Employee from such covered Employee's spouse;
(iv) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
(v) a dependent child who ceases to be a dependent child under the terms of this Plan.
(vi) the Company's filing for Chapter 11 reorganization as it would affect retiree coverage.

ARTICLE VII

MISCELLANEOUS

7.1 Component Plans Control

This Plan document describes generally the benefits under the Component Plans. The detailed coverages provided under a Component Plan are set forth in that Component Plan; in case of any conflict between the terms of this Plan document and the terms of a Component Plan, the terms of the Component Plan shall control.

Certificates or summaries setting forth the details of the coverages provided under Component Plans have been or will be distributed to Eligible Employees enrolled for coverage under the Component Plan(s).

7.2 Applicable Law

Except to the extent superseded by the laws of the United States, this Plan and each Component Plan and all rights and duties thereunder shall be governed, construed, and administered in accordance with the laws of the State of California.

7.3 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.

7.4 Plan Not An Employment Contract

The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in the plan or any Component Plan shall enlarge nor diminish any employment rights of an Eligible Employee.

7.5 Alienation of Benefits.

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

7.6 Facility of Payment.

If the Employer deems any person incapable of receiving Benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

7.7 Proof of Claim.

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

7.8 Status of Benefits.

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

7.9 Lost Distributees.

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

7.10 Source of Payments.

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

7.11 Heirs and Assigns.

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

7.12 Headings and Captions.

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

7.13 Tax Effects.

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

7.14 Multiple Functions.

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

7.15 Gender and Form.

Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

7.16 No Reversion to Employer.

At no time shall any part of Plan assets be used for, or diverted to, purposes other than for the exclusive benefit of Plan participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

ARTICLE VIII

AMENDMENT AND TERMINATION

8.1 Amendment

Any part or all of the Plan or of any Component Plan may be amended in writing by the Employer at any time or from time to time; any contract providing insured benefits may be so amended by the Employer with the agreement of the insurance company or service company at any time or from time to time; and any insurance company or service company may be removed or changed by the Employer at any time and from time to time.

Any amendment must be in writing and shall become effective upon adoption by the County of Santa Barbara (Plan Administrator), or at such time as may be otherwise specified in the amendment. No amendment shall operate to reduce the amount of any benefit payment otherwise payable under the Plan for charges incurred prior to the effective date of such amendment.

8.2 Termination

Any Component Plan and any contract providing insured benefits may be terminated at any time by action of the Employer. (The Employer must notify Eligible Employees within thirty (30) days before such termination.) If a Component Plan is terminated and replaced with another plan that provides similar benefits, Salary Reduction amounts that were designated to pay premiums for the terminated plan will be applied instead to pay premiums for the new plan. If a Component Plan is terminated and not replaced with another plan that provides similar benefits, Salary Reduction amounts will terminate as of the end of the pay period in which the Component Plan is terminated. No termination or substitution shall operate to reduce the amount of any benefit payment otherwise payable under the plan for charges incurred prior to the effective date of such termination or substitution.

Notwithstanding the above, the Employer reserves the right to terminate or amend the Plan at any time if the Plan is deemed not to be in compliance with Applicable Law.

8.3 Non-Transferability of Interest and Facility of Payment

Except as otherwise expressly permitted by a Component Plan, the interest of persons entitled to benefits under a Component Plan are not subject to their debts or other obligations and, except as may be required by the tax withholding provisions of the Code or any state's income tax act, may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered. When any person entitled to benefits under the Plan is under legal disability or in the Employer's opinion is in any way incapacitated so as to be unable to manage his affairs, the Employer may cause such person's benefits to be paid to such person's legal representative for his benefit, or to be applied for the benefit of such person in any other manner that the Employer may determine.

8.4 Mistake of Fact

Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof. The Employer shall not be liable in any manner for any determination of fact made in good faith.

8.5 Cost of Administering the Plan

The costs and expenses incurred by the Employer in administering the Plan shall be paid by the Employer out of general assets plus forfeitures described in Section 4.7.

ADOPTION OF THE PLAN

As evidence of its adoption of this Section 125 Plan, the County of Santa Barbara has caused this instrument to be signed by its officers thereunder duly authorized and its County seal attached hereto.

Executed this _____ day of _____, 20___.

COUNTY OF SANTA BARBARA

By: _____

Brooks Firestone
(Chair, Board of Supervisors)

ATTEST:

Michael Brown
Clerk of the Board of Supervisors

By: _____
Deputy Clerk

APPROVED AS TO FORM:
Stephen Shane Stark
County Counsel

By: _____
Deputy County Counsel

APPROVED AS TO FORM:
Robert W. Geis
Auditor-Controller

By: _____

COUNTY OF SANTA BARBARA

SECTION 125 PLAN

SCHEDULE A – COMPONENT BENEFIT PLANS

As of the effective date of this plan document, the following are the Component Plans included in the Plan:

As of the effective date, the following are the Component Plans included in the Plan:

1. The County of Santa Barbara Self-Funded Dental Plan.

2. Any service contract which the County of Santa Barbara has entered into with a Health Maintenance Organization for medical plan services, including employee assistance program services.

3. Any service contract which the County of Santa Barbara has entered into with a Health Maintenance Organization for dental plan services.

4. The County of Santa Barbara Health Care Reimbursement Account.

5. The County of Santa Barbara Dependent Care Reimbursement Account.

6. The County of Santa Barbara Life Insurance Program.

7. The County of Santa Barbara Personal Accident Insurance Program.

8. Any service contract which the County of Santa Barbara has entered into with an insurance carrier for indemnity medical or dental benefits, including employee assistance program services and high deductible health plans.

9. Any arrangement for indemnity medical or dental benefits that is sponsored by the County of Santa Barbara for firefighters and/or Superior Court employees.

10. The County of Santa Barbara Health Savings Account Component Plan.

COUNTY OF SANTA BARBARA

SECTION 125 PLAN

SCHEDULE B - EMPLOYEE FLEXIBLE SPENDING CONTRIBUTION LIMITATIONS

	Minimum Biweekly Amount	*Maximum Annual Amount*
Health Care Reimbursement Account	$5.00	$5,000.00
Dependent Care Reimbursement Account	$5.00	$5,000.00

COUNTY OF SANTA BARBARA

HEALTH CARE REIMBURSEMENT ACCOUNT PLAN

A COMPONENT PLAN OF THE
COUNTY OF SANTA BARBARA
I.R.S. SECTION 125 PLAN

Effective May 1, 1989

Revised December 1, 2005

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INTRODUCTION

County of Santa Barbara (hereinafter "Employer") establishes this "County of Santa Barbara Health Care Reimbursement Account Plan" effective May 1, 1989 and revised as of January 1, 2005, to allow Eligible Employees of the Employer to elect to receive medical, dental and vision care reimbursement benefits which are excludable from gross income under Section 213(d) of the Internal Revenue Code of 1986, as amended (hereinafter "Code"), as provided herein and in the terms of the "County of Santa Barbara Section 125 Plan" (hereinafter "Plan").

This Health Care Reimbursement Account is a Component Plan of the County of Santa Barbara Section 125 Plan and, except to the extent otherwise expressly provided herein, is governed by the rules and regulations of the Plan. It is intended to qualify as a medical reimbursement plan within the meaning of Section 105(b) of the Code and to meet the requirements of any other applicable provisions of law.

ARTICLE 1

DEFINITIONS

The definitions in the Section 125 Plan apply to this Component Plan as well, with the following additions.

1.1 Dependent shall mean any of the following:

(a) A Participant's spouse not legally separated from the Participant.

(b) Each of a Participant's unmarried children (as defined in Section 1.5 of the County of Santa Barbara Section 125 Plan) who has not attained the age of 23 and is dependent upon the Participant for over 50% of his or her support.

(c) Each of a Participant's unmarried children (as defined in Section 1.5 of the County of Santa Barbara Section 125 Plan) who became incapacitated prior to attainment of age 23 and who is dependent on the Participant for over 50% of his or her support.

(d) The Participant's domestic partner, if (i) the domestic partnership is registered with the State of California or with a county or city within the State of California; and (ii) the domestic partner is a tax dependent of the Participant as defined in section 152(d) of the Internal Revenue Code (determined without regard to section 152(d)(1)(B) thereof). In addition, the domestic partner must also be: the Participant's sole spousal equivalent, be 18 years old or older, be mentally competent to contract, reside with the Participant and intend to do so indefinitely, be jointly responsible with the Participant for their common welfare and financial obligations, be unmarried and not related to the Participant by blood to a degree of closeness as to bar marriage in the state of residence, and has not filed a Statement of Termination of Domestic Partnership within the last 6 months. The Participant must also be unmarried.

(e) An unmarried person under age 23 for whom the Participant has legal guardianship under a court order provided:

(i) the person was under the age of 18 at the time the court order was issued,

(ii) the person is dependent upon the Participant for over 50% of his or her support,

(iii) if the person is not related to the Participant as specified in Internal Revenue Code § 152(d)(2)(A) through (G), the person must share the Participant's principal place of abode and be a member of the household for the entire year, and

(iv) the person is not the "qualifying child" of another individual. For this purpose, the term "qualifying child" is defined in Internal Revenue Code § 152(c).

Any unmarried child (as described in (b) and (c) above) who is a "qualifying child" of any other taxpayer as defined in Code § 152(c) (other than the child's other parent in cases of divorce or separation, as described below) is not a Dependent of the Participant.

Special Rule for Divorce/Separation. The requirement in (b) and (c) above that the Participant provide over 50% of a child's support does not apply if (i) the Participant and the child's other parent are divorced or legally separated under a decree of separate maintenance, are separated under a written separation agreement, or currently live apart and lived apart at all times during the last six months of the previous calendar year; (ii) the child receives over 50% of his or her support during the calendar year from his or her parents; and (iii) the child is in the custody of one or both of his or her parents more than 50% of the calendar year.

1.2 Health Care Reimbursement Account (HCRA) shall mean County of Santa Barbara Health Care Reimbursement Account Plan.

1.3 Medical Expenses shall mean amounts paid for medical care within the meaning of Internal Revenue Code §213(d) and regulations and rulings thereto published by the Internal Revenue Service.

1.4 Plan or Cafeteria Plan shall mean County of Santa Barbara Section 125 Plan.

1.5 Qualifying Medical Expenses shall mean Medical Expenses for which the Participant is not reimbursed pursuant to any medical policy or program established or maintained by the Employer, and which have been incurred and paid by or on behalf of the Participant or a person who is the Participant's Dependent.

1.6 Grace Period shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

ARTICLE II

SCOPE OF THE PLAN

2.1 Subject to the conditions and limitations set forth in this Health Care Reimbursement Account Plan document and in the Section 125 Plan, each Participant may elect to receive payment under the HCRA for his or her Qualifying Medical Expenses in lieu of an equal amount of cash. This election must be made prior to the beginning of the Plan Year for current employees, and within 30 days after the date of eligibility for employees who become eligible after the beginning of a Plan Year.

ARTICLE III

PARTICIPATION

3.1 Participation in this Health Care Reimbursement Account component shall commence and terminate simultaneously with participation in the Cafeteria Plan, subject to the same conditions and limitations set forth in Article II and Article VI of the Cafeteria Plan.

3.2 Reimbursement After Termination of Participation; COBRA

(a) When a Participant ceases to be a Participant, the Participant's Compensation Reduction Agreement and election to participate will terminate. Except as otherwise provided in Section 4.2(c) (regarding certain individuals who may be reimbursed for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Qualifying Medical Expenses incurred after the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Qualifying Medical Expenses incurred during the Plan Year prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 4.2(c), provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

(b) Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health Care Reimbursement Account Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under this Health Care Reimbursement Account Plan the day before the qualifying event. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive balance in their Health Care Reimbursement Account at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Notwithstanding the

foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage on the last day of a Plan Year may be entitled to reimbursement of Qualifying Medical Expenses incurred during the Grace Period following that Plan Year in accordance with Section 4.2(c).

Contributions for COBRA coverage may be paid on a pre-tax basis for current employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (1) because the Employee ceases to be eligible because of a reduction of hours, or (2) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for Health Care Reimbursement Account benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provided coverage that extends into a subsequent Plan Year).

ARTICLE IV

PAYMENT PROCEDURE

4.1 Establishment of Health Care Reimbursement Account

(a) Each Plan Year, the Employer will credit an amount to each Participant's account, as specified in Section 4.2 of the Cafeteria Plan.

(b) In accordance with Cafeteria Plan Section 4.2, each Participant shall designate the amount (or portion of the total) to be applied during the Plan Year to the Participant's Health Care Reimbursement Account. This designation shall be made prior to the beginning of the Plan Year, except that employees who become eligible after the beginning of a Plan Year have 30 days after the date of eligibility in which to make this designation.

4.2 Employee Reimbursements

(a) A Participant may elect reimbursement for his or her Qualifying Medical or Dental Expenses on a claim form to be submitted to County of Santa Barbara Department of Auditor/Controller. The maximum dollar amount elected by the Participant for reimbursement of Qualifying Medical or Dental Expenses incurred during the Plan Year (reduced by prior reimbursements during the Plan Year) shall be available at all times during the Plan Year, regardless of the actual amount credited to the Participant's Health Care Reimbursement Account.

(b) Amounts credited to a Participant's Health Care Reimbursement Account and not applied as reimbursement payments for Qualifying Medical Expenses incurred during the Plan Year or during the Grace Period immediately following the end of the Plan Year, shall be forfeited and returned to the general assets of the Employer to offset the costs of plan administration.

(c) Grace Periods; Special Rules for Claims Incurred During a Grace Period

(1) Notwithstanding any contrary provision in this Plan and subject to any limits on the maximum annual benefits that may be reimbursed, an individual may be reimbursed for Qualifying Medical Expenses incurred during a Grace Period from amounts remaining in his or her Health Care Reimbursement Account at the end of the Plan Year to which that Grace Period relates if he or she is either a Participant or a Dependent who has coverage under this Plan on the last day of the Plan Year.

(2) Qualifying Medical Expenses incurred during a Grace Period and approved for reimbursement will be reimbursed first from any available balance remaining in the Health Care Reimbursement Account at the end of the Plan

Year to which the Grace Period relates and then from any amounts that are available to reimburse expenses that are incurred in the current Plan Year.

(3) Claims for reimbursement of Qualifying Medical Care expenses incurred during a Grace period, and which are to be reimbursed from any available balance remaining in the Health Care Reimbursement Account at the end of the Plan Year to which the Grace Period relates, must be submitted no later than June 15 following the close of the Plan Year to which the Grace Period relates.

4.3 Documentation Processing

The Employer will process and review all claim forms that are submitted by Participants. The scope of the Employer's review with respect to this Health Care Reimbursement Account is to determine:

(a) whether the Participant's expenses appear to be Qualifying Medical Expenses, and

(b) whether the Participant's claim form is accompanied by the required documentation.

ARTICLE V

GENERAL PROVISIONS

5.1 Participant Responsibility

Each Participant is responsible for accumulating and submitting the documentation required to accompany the claim form. Claim forms which are not accompanied by properly documented expense vouchers may be returned to the Participant by the Employer for further documentation. Each Participant who fails to supply additional documentation by June 15 following the end of the Grace Period that immediately follows the Plan Year shall be deemed not to have requested reimbursement for the amounts in question. No Participant shall have any rights or be entitled to any reimbursement under the Health Care Reimbursement Account unless a claim form is submitted as specified.

5.2 Administration of the Health Care Reimbursement Account

The Health Care Reimbursement Account shall be administered in accordance with provisions set forth in the County of Santa Barbara Section 125 Plan.

5.3 Termination of Health Care Reimbursement Account

The Employer reserves the right to amend or terminate this Health Care Reimbursement Account in whole or in part at any time, subject to the terms of Section 8.2 of the Plan.

5.4 Claims Procedure and Appeal

The procedures in Article V of the Cafeteria Plan apply to this Health Care Reimbursement Account as well.

ARTICLE VI

HIPAA PROVISIONS

6.01 Purpose.

The provisions of this Article VI are intended to comply with certain administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, "HIPAA") specifically, the rules under HIPAA pertaining to: the privacy of Protected Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the "Privacy Rule"); and the security of electronic Protected Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart C, as it may be amended from time to time (the "Security Rule"). This Article VI shall be effective as of April 14, 2003 except that Section 6.09 pertaining to the Security Rule is effective as of April 20, 2005.

6.02 Inconsistent Provisions. This Article VI shall supersede any provisions of the Plan to the extent those provisions are inconsistent with this Article.

6.03 Definitions

Each capitalized term used in this Article VI that is not otherwise defined in the Plan shall have the meaning ascribed to it under HIPAA.

6.04 Required Uses and Disclosures of Protected Health Information.

Except as otherwise set forth herein, the Plan (including its Business Associates) or any Health Insurance Issuer may disclose Protected Health Information to the Plan Sponsor for the following required uses and disclosures:

(a) for disclosure to the Secretary of Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule; and

(b) for disclosure to a Plan Participant, Spouse or Dependent of that individual's Protected Health Information upon the individual's written request or in appropriate response to an exercise by the Plan Participant, Spouse or Dependent of any other of his or her individual rights with respect to Protected Health Information, all in accordance with the requirements of the Privacy Rule;

(c) for use by the Plan Sponsor or disclosure to other persons, as required by HIPAA or other applicable law, provided that nothing in this Section 6.04(c) shall permit or require use by, or disclosure of Protected Health Information to, the Plan Sponsor to the extent such use or disclosure is prohibited by HIPAA.

6.05 Permitted Uses and Disclosures of Protected Health Information.

Except as otherwise set forth herein, the Protected Health Information created or received by the Plan (or its Business Associates) or any Health Insurance Issuer providing benefits under the Plan shall be permitted to be disclosed to the Plan Sponsor (upon receipt from the Plan

Sponsor of a certification that it shall comply with the restrictions as to the use or disclosure of PHI and the other provisions set forth in this Article) for purposes of the plan's administration functions that the Plan Sponsor performs on behalf of the Plan, or as otherwise required by HIPAA, including without limitation:

(a) for Treatment, Payment or Health Care Operations (including, but not limited to, determinations of eligibility, coverage, and cost sharing amounts; coordination of benefits; adjudication of health benefit claims (including appeals and other payment disputes); subrogation of health benefit claims; establishing employee contributions; billing and collection activities; obtaining payment under a contract of reinsurance; medical necessity reviews or reviews of the appropriateness of care or justification of charges; utilization review; population-based activities relating to improving health or reducing health care costs; case management and care coordination; the operation of wellness, prevention and disease management programs; rating provider performance; conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development, such as development or improvement of method of payment or coverage policies; business management and general administrative activities of the Plan (including customer service and resolution of internal grievances);

(b) for purposes relating to subpoenas and other court orders;

(c) pursuant to and in accordance with a valid authorization under the Privacy Rule; and

(d) as otherwise permitted by HIPAA.

Nothing in this Section 6.05 shall permit or require the disclosure of Protected Health Information to the Plan Sponsor to the extent such disclosure is prohibited by HIPAA.

6.06 Requirements of Plan Sponsor. The Plan Sponsor shall:

(a) not use or disclose Protected Health Information received from the Plan or any Health Insurance Issuer providing benefits under the Plan other than as permitted by the Plan document for Plan Administration, or as otherwise required by law;

(b) ensure that any agent (including a subcontractor) to whom the Plan Sponsor provides Protected Health Information received from the Plan or any Health Insurance Issuer providing benefits thereunder agrees to the same restrictions and conditions with respect to Protected Health Information as apply to the Plan Sponsor under this Article VI;

(c) not use or disclose Protected Health Information received from the Plan or any Health Insurance Issuer providing benefits under the Plan, for employment-related actions or decisions or in connection with any employee benefit plan or benefit provided by the Plan Sponsor other than the Plan or a health benefit provided under the Plan;

(d) report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures required or permitted under this Article VI and of which the Plan Sponsor becomes aware;

(e) make the Protected Health Information of a Plan Participant, Spouse or Dependent available to that individual, upon the individual's written request, in accordance with the requirements of the Privacy Rule;

(f) incorporate amendments of Protected Health Information of a Plan Participant, Spouse or Dependent as and to the extent required by the Privacy Rule;

(g) make available to a Plan Participant, Spouse or Dependent upon the individual's written request, an accounting of disclosures of Protected Health Information as and to the extent required by the Privacy Rule;

(h) make the Plan Sponsor's internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;

(i) if feasible, return or destroy all Protected Health Information received from the Plan or any Health Insurance Issuer providing benefits under the Plan, that the Plan Sponsor maintains and retain no copies thereof; or, if such return or destruction is not feasible, limit further uses and disclosures of Protected Health Information to the purposes that make the destruction or return infeasible; and

(j) ensure that the requirements set forth in Section 6.07 are satisfied with respect to Protected Health Information.

6.07 Access to Protected Health Information.

Access. Access to and use/disclosure of Protected Health Information shall be limited to employees or agents of Plan Sponsor who perform the functions relating to Plan administration on behalf of or in connection with the Plan, as described in Sections 6.04 and 6.05, in order to perform such activities. Employees of the County who may have access to Protected Health Information include the Director of Human Resources, Employee Benefits Manager, Privacy Officer, and other employees only as needed for administration of the Plan.

6.08 Mechanism for Resolving Non-Compliance.

Issues regarding non-compliance by persons described in Section 6.07 will be resolved pursuant to the County's policy regarding protection of Protected Health Information and the County's Human Resources, employee discipline and sanctions and mitigation policies.

6.09 HIPAA Security Measures

The Plan Sponsor will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that is created, received, maintained, or transmitted on behalf of the Plan,

(b) Ensure that the access provisions discussed in Section 6.07 above, specific to electronic Protected Health Information, are supported by reasonable and appropriate security measures,

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the electronic Protected Health Information, and

(d) Report to the Plan any security incident of which it becomes aware concerning electronic Protected Health Information.

ARTICLE VII

ENTIRE AGREEMENT

This document sets forth the entire Plan. Except as provided in this Plan, no other employee benefit plan which is, or may hereafter be, maintained by the Employer on a non-elective basis shall constitute a part of this Plan.

COUNTY OF SANTA BARBARA

DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN

A COMPONENT PLAN OF THE
COUNTY OF SANTA BARBARA
I.R.S SECTION 125 PLAN

Effective May 1, 1989

Revised December 1, 2005

INTRODUCTION

The County of Santa Barbara (hereinafter "Employer") establishes this "County of Santa Barbara Dependent Care Reimbursement Account" (hereinafter "DCRA") effective May 1, 1989 and revised as of January 1, 2005, to allow Eligible Employees of the Employer to elect to receive dependent care assistance benefits which are excludable from gross income under Section 129(a) of the Internal Revenue Code of 1986, as amended (hereinafter "Code"), as provided herein and in the terms of the "County of Santa Barbara Section 125 Plan" (hereinafter Plan).

This DCRA is a Component Plan of the County of Santa Barbara Section 125 Plan and, except to the extent otherwise expressly provided herein, is governed by the rules and regulations of the Plan. The DCRA is intended to qualify as a "dependent care assistance program" within the meeting of Section 129(d) of the Code and to meet the requirements of any other applicable provisions of law.

CONTENTS

ARTICLE 1

PURPOSE

The purpose of this Plan is to reimburse Eligible Employees of the Employer for the cost of dependent care assistance incurred by them in exchange for a reduction in the amount of salary that would otherwise be payable by the Employer to such employees, but without such reimbursement being included in the employees' gross income for federal income, Social Security and, where permissible, state and local income tax purposes. It is the intent of the Employer that this Plan qualify as a "cafeteria plan" within the meaning of section 125 of the Code, and that any Benefits paid under the Plan be eligible for exclusion from gross income to the maximum extent possible under section 129 of the Code. The Employer presently provides, and may continue to provide, a variety of other employee benefits to some or all of its employees on a non-elective basis. The Benefits provided under this Plan shall be in addition to and not in lieu of such other benefits, and such other benefits shall not constitute a part of this Plan.

ARTICLE II

EFFECTIVE DATE AND PLAN YEAR

The effective date of this Plan shall be May 1, 1989. The records of the Plan shall be kept on the basis of a calendar Plan Year beginning on each January 1 and ending on each subsequent December 31.

ARTICLE III

DEFINITIONS

3.01 Benefits. "Benefits" means reimbursements under this Plan of Eligible Expenses incurred by Participants.

3.02 Code. "Code" means the Internal Revenue Code of 1986, as now in effect or as it may be amended hereafter, and includes any regulations or rulings issued thereunder.

3.03 Dependent. The "Dependents" of a Participant for each Plan Year shall include his spouse and any of the following individuals who depend on the Participant for more than one-half (1/2) of their support during the Plan Year:

(a) his son or daughter, a descendent of either, or stepson or stepdaughter;
(b) his father or mother, an ancestor, brother or sister of either, or stepfather or stepmother;
(c) his brother or sister, a son or daughter of either, or stepbrother or stepsister;
(d) his son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; or
(e) any other individual whose principal residence is with the Participant and who is a member of the Participant's household during such Plan Year.

3.04 Dependent Care Recipient. A "Dependent Care Recipient" qualified to receive Benefits under Article V of the Plan is any Dependent who is either:

(a) a Child (as defined in Section 1.5 of the County of Santa Barbara Section 125 Plan) of a Participant who is under the age of thirteen (13) and who is the Participant's "qualifying child" as defined in Internal Revenue Code § 152(c); or

(b) any Dependent (other than the Participant's spouse) who (i) is physically or mentally incapable of caring for himself or herself, and (ii) has the same principal place of abode as the Participant for more than one-half of the Plan Year, and (iii) meets the applicable requirements for a dependent under Internal Revenue Code § 152; or

(c) the Participant's spouse if the spouse 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 the Plan Year.

3.05 Earned Income. "Earned Income" means all income derived from wages, salaries, tips, commissions, self-employment (as defined in Code section 32(c)(2)(A)(ii)) and other employment compensation (such as disability benefits), but such term does not include any amounts which are: (a) received as Benefits under the Plan or any other dependent care assistance program under Code section 129; (b) received as a pension or annuity; or (c) received as unemployment or worker's compensation. In the case of a spouse who during at least five months of each of the calendar years covered by the Plan Year is a full-time student at an Educational Institution or a spouse who during any month is incapable of self-care, such spouse shall be deemed for each of such months to be gainfully employed and to have earned income in that month of (i) $200, if the Participant incurs Eligible Expenses during the Plan Year for only one Dependent Care Recipient, and (ii) $400, if the Participant incurs Eligible Expenses during the Plan Year for two or more Dependent Care Recipients.

3.06 Educational Institution. "Educational Institution" means any educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

3.07 Eligible Employees. An "Eligible Employee" is any Employee who is eligible to participate in the Plan under Section 4.01.

3.08 Eligible Expenses. "Eligible Expenses" means all expenses for Qualifying Dependent Care Services incurred by a Participant or by his or her Spouse which are paid to a Qualified Caregiver or a Qualified Dependent Care Center.

3.09 Employer. "Employer" means the County of Santa Barbara. "Participating Employer" means any other employer that is affiliated with Employer, within the meaning of the controlled group rules of Sections 414(b), (c) or (m) of the Code, that has adopted this Plan (or an amended version of this Plan) after obtaining formal approval for such adoption from the County of Santa Barbara.

3.10 Employee. An "Employee" is any person on the payroll of the Employer or Participating Employer.

3.11 Qualified Caregiver. A "Qualified Caregiver" is a person performing Qualifying Dependent Care Services who is not a Dependent (as defined in Section 3.03). A child of a Participant can only be a Qualified Caregiver if the child is age 19 or older and does not depend on the Participant for over one-half of his or her support.

3.12 Qualified Dependent Care Center. A "Qualified Dependent Care Center" is a licensed dependent care center that provides dependent care for more than six individuals and operates in compliance with all applicable laws of both the state and the town, city or village in which it is located.

3.13 Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means services which are performed to enable a Participant (and spouse, if any) to remain gainfully employed, which are related to the care of one or more Dependent Care Recipients (including household services related to such care), and which are performed either within or outside the home of the Participant. If such services are performed outside the Participant's home, they can only be incurred for (1) the care of a Dependent Care Recipient who meets the requirements of Section 3.04(a); or (2) the care of any other Dependent Care Recipient who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable sate and local laws and regulations. Such Qualifying Dependent Care Services must be performed during the Plan Year and after the Participant has filed an election to receive Benefits under the procedures described in Article 7.

3.14 Participant. A "Participant" is any Eligible Employee who is a Participant in the Dependent Care Reimbursement Account Plan under Section 4.02.

3.15 Plan. The "Plan" is the County of Santa Barbara's Dependent Care Reimbursement Account Plan, as it may be amended from time to time.

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

3.17 Grace Period shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

ARTICLE IV

ELIGIBILITY AND PARTICIPATION

4.01 Eligibility. All full-time and part-time regular Employees of the Employer.

4.02 Participation. Each Employee who is eligible to participate in the Plan under Section 4.01 shall become a Participant in this Plan on the later of the effective date of this Plan or the first day of the pay period on or after their date of hire into a regular County position. A Participant who terminates or is discharged from employment with the Employer shall cease to be a Participant in the Plan on the last day of the pay period in which an individual ceases to be an Eligible Employee. However, claims for reimbursement for Eligible Expenses for Qualifying Dependent Care Services provided while the Participant was a Participant can continue to be submitted to the Employer, in accordance with Article VIII.

ARTICLE V

BENEFITS

5.01 General Benefits. From the effective date of the Plan and for so long as this Plan is continued, every Participant in the Plan shall be eligible to elect to reduce his salary and receive instead Benefits for all Eligible Expenses incurred by such Participant or his or her spouse for Qualifying Dependent Care Services which are provided during the Plan Year and after the date on which the Participant has filed an election to receive such Benefits under the procedures described in Section 7. The maximum amount of such Benefits payable in response to any claim filed under the Claims Procedures described in Section 8 shall not exceed the Participant's salary reduction contributions with respect to such Benefits, minus all previous reimbursements of Eligible Dependent Care Expenses paid during the preceding portion of the Plan Year. No Benefits shall be paid hereunder for Qualifying Dependent Care Services provided after the date on which any Participant ceases to be an Employee.

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

(a) $5,000 (or $2,500 in the case of a married Participant filing a separate federal income tax return from his spouse);
(b) his Earned Income for such Plan Year; or
(c) the Earned Income of his spouse for such Plan Year.

A Participant who is not married at the close of a Plan Year may not receive Benefits for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of $5,000 or his Earned Income for the Plan Year. Notwithstanding the above, the maximum Benefits paid under this Plan must also be reduced by the amount of any tax-exempt dependent care assistance benefits received by the Participant or his spouse from any other employer during the Plan Year.

5.03 Cash Alternative. Any Participant who has not elected under the procedures described in Article VII to receive Benefits will be assumed to have elected cash benefits, and his salary will not be reduced to cover the payment of non-cash Benefits under this Plan.

5.04 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or Benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then such Plan Administrator may select and exclude from coverage under the Plan such highly compensated Participants and/or reduce contributions and/or Benefits under the Plan by such highly compensated Participants, all as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

ARTICLE VI

LIMITATION

6.01 Maximum Overall Contributions. No Participant shall be entitled to reduce compensation by more than the aggregate maximum amount of Benefits specified in Sections 5.02 and 5.04 above.

6.02. Forfeiture of Unused Benefits. A Participant shall receive no reimbursement for Benefits elected, but unused, during a Plan Year or during the Grace Period that immediately follows that Plan Year.

6.03 Grace Periods; Special Rules for Claims Incurred During a Grace Period

(a) Notwithstanding any contrary provision in this Plan and subject to any limits on the maximum annual benefits that may be reimbursed, an individual may be reimbursed for Eligible Expenses incurred during a Grace Period from the unused balance in his or her reimbursement account at the end of the Plan Year to which that Grace Period relates if he or she is either a Participant or a Dependent who has coverage under this Plan on the last day of the Plan Year.

(b) Eligible Expenses incurred during a Grace Period and approved for reimbursement will be reimbursed first from any available balance remaining in the reimbursement account at the end of the Plan Year to which the Grace Period relates and then from any amounts that are available to reimburse expenses that are incurred in the current Plan Year.

(c) Claims for reimbursement of Eligible Expenses incurred during a Grace Period, and which are to be reimbursed from any available balance remaining in the Health Care Reimbursement Account at the end of the Plan Year to which the Grace Period relates, must be submitted no later than June 15 following the close of the Plan Year to which the Grace Period relates.

ARTICLE VII

ELECTIONS

7.01 Annual Elections. For any Plan Year, a Participant may affirmatively elect to receive dependent care assistance Benefits by filing an Election Form, which may be obtained from the Employer, and which shall specify the exact amount of the Participant's salary which the Participant wishes to be paid in Benefits instead of in cash compensation during the period covered by the election. The initial election filed by any Participant who is an Eligible Employee shall become effective on the first day of the first biweekly pay period during which or after such election form is properly signed and dated, and submitted by the Participant and accepted by the Employer. Any subsequent election filed by such a Participant shall become effective on the first day of the subsequent Plan Year for which such election is made. If any Participant with eligible Dependents fails to file an Election Form by the end of the *"thirty (30) day"* period after he becomes a Participant, he shall be deemed to have elected to receive cash benefits under this Plan in accordance with Section 5.03.

7.02 Duration of Elections. Once effective, any such affirmative or deemed election shall remain in effect until the end of the Plan Year for which it was made, unless a change is made pursuant to Section 7.03 below.

7.03 Mid-Year Changes in Elections on Account of Life Events. A Participant may change his election for the remainder of any Plan Year for which an election has been made or deemed made only if such change in his election is on account of, and consistent with, a Life Event. A "Life Event" shall be an event in the life of the Participant which, as determined in the discretion of the Plan Administrator, increases or decreases the number of Dependents qualifying for Benefits under this Plan, including, without limitation, marriage or divorce of the Participant, death of a spouse or other Dependent, birth or adoption of a Dependent, termination or commencement of a spouse's employment, a switching from full-time to part-time employment status by the Participant's spouse and the taking of an unpaid leave of absence by the Participant or his or her spouse. In the event that Plan Contributions and the corresponding Plan Benefits for the balance of the Plan Year are terminated as the result of such a change in an election, any Plan Contribution made for the portion of the Plan Year extending beyond such election revocation date will be refunded to the Participant.

7.04 Revocation of Election on Termination of Service. The election of any Participant who terminates or is discharged from Employment with the Employer, or who ceases to be an Eligible Employee, will be automatically terminated, effective as of the effective date of such termination or discharge. No Benefits will be paid for any expenses incurred for Qualifying Dependent Care Services provided after the effective date of any revocation of a Participant's election. Any Plan Contributions made for the portion of the Plan Year extending beyond such election revocation date will be refunded to the Participant. If the Participant becomes an Eligible Employee again within the same Plan Year, the Participant may not make a new election for the remainder of such Plan Year with respect to any Benefits that were terminated as of the effective date of such termination or discharge.

ARTICLE VIII

CLAIMS PROCEDURES

8.01 Benefits. Each Participant who desires to receive reimbursement under the Plan for Eligible Expenses incurred for Qualifying Dependent Care Services shall submit to the County of Santa Barbara Auditor-Controller, or his or her designee, at the times indicated in Section 8.03, a form provided by the Employer, or responses to other supplementary factual requests, containing the following information:

(a) the Dependent or Dependents for whom the Eligible Expenses were incurred, the age(s) of such Dependent(s), and their relationship to the Participant;

(b) if any of the Qualifying Dependent Care Services were performed outside the Participant's home for a Dependent Care Recipient other than one specified in Section 3.04(a), a statement as to whether said Dependent Care Recipient regularly spends at least eight (8) hours a day in the Participant's home;

(c) if any of the Qualifying Dependent Care Services were provided for a Dependent who is not a child of the Participant, but who is capable of self-care, a statement that such Dependent is under the age of thirteen (13) and has gross income of less than the limits specified in Section 3.04(c);

(d) a statement that the Dependent is the Participant's "qualifying child" or "qualifying relative," as applicable;

(e) for Dependents required by Section 3.04 to have the same principal place of abode as the Participant, a statement that the Dependent meets such requirement;

(f) the nature and dates of performance of the Qualifying Dependent Care Services for which cost the Participant wishes to be reimbursed;

(g) the relationship, if any, to the Participant of the person(s) who performed the Qualifying Dependent Care Services;

(h) if the Qualifying Dependent Care Services were performed by a child of the Participant, the age of such child and a statement that the child does not depend on the Participant for more than one-half of his or her support;

(i) a statement indicating that the Participant will include on his or her Federal income tax return the name, address, and (except in the case of a tax-exempt Qualified Dependent Care Center) the taxpayer identification number of the provider of the Qualifying Dependent Care Services;

(j) if the Participant is married, whether the Participant plans to file a separate Federal income tax return from his spouse;

(k) if the Participant is married and (1) if his spouse is employed, a statement of the spouse's Earned Income or (2) if his spouse is not employed, a statement that (A) the spouse is incapacitated or (B) the spouse is a student, indicating the months of the year during which the spouse attends an Educational Institution on a full-time basis;

(l) a statement as to the amount, if any, of tax-exempt dependent care assistance benefits received from any other employer by the Participant or his spouse during the Plan Year; and

(m) evidence of indebtedness or payment by the Participant to the third party who performed the Qualifying Dependent Care Services.

As soon as is administratively feasible following the receipt of the claim form, the Plan Administrator shall review all the forms submitted by Participants in accordance with the foregoing procedures and shall pay each Participant the Benefits which each Participant is entitled to receive under the Plan, in accordance with the Plan.

8.02 Cash Benefits. Each Participant electing to receive cash benefits shall receive his compensation without any reduction.

8.03 Time Limit. No Benefits shall be paid or expense reimbursed under Section 8.01 for any Plan Year, or for the Grace Period which immediately follows such Plan Year, unless the Participant applies for such benefit or reimbursement no later than June 15 following the close of the Plan Year.

ARTICLE IX

PAYMENT OF BENEFITS

9.01 Source of Benefit Payments. The sole source for payment of Benefits under this Plan shall be the unfunded accounts established for each Participant pursuant to his election under Section 5.01 to receive such Benefits. The Plan Administrator shall pay to each Participant the Benefits which he is entitled to receive under this Plan, and his reimbursement account under the Plan shall be debited accordingly. The aggregate reimbursements made as of any point during the Plan Year shall not exceed the Participant's total Plan contributions for Benefits previously made during the Plan Year.

9.02 Forfeitability of Unpaid Benefits. Any balance remaining in the Participant's reimbursement account after the last Eligible Expenses have been drawn down for a given Plan Year shall be forfeited by the Participant, and the account balance reduced to zero.

9.03 Annual Statement. The Plan Administrator shall forward to each Participant receiving Benefits during any Plan Year a statement that shall show (as determined by the Plan Administrator) either the total amount of such Benefits received by such Participant during that Plan Year, or the total Plan contributions for Benefits made by such Participant during the Plan Year. Such statement shall be furnished to the Participant by the January 31st following the end of such Plan Year.

ARTICLE X

REVIEW PROCEDURE FOR DENIED CLAIMS

10.01 Notice of Claim Denial. If any claim for Benefits under this Plan is denied in whole or in part, the claimant shall be furnished promptly by the Auditor-Controller a written notice setting forth the following:

(a) a specific reason or reasons for the denial;
(b) specific reference to pertinent Plan provisions upon which the denial is based;
(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
(d) an explanation of the Plan's claim review procedures, as set forth below in Sections 10.02 and 10.03.

Failure by the Plan Administrator to respond to a claim within *thirty (30) days* following the end of the biweekly pay period in which such claim was submitted shall be deemed a denial.

10.02 Appeal Procedures. Within *sixty (60) days* after denial of any claim for Benefits under this Plan, the claimant may request in writing a review of the denial by the Appeals Committee. Any claimant seeking review hereunder is entitled to examine all pertinent documents, and to submit issues and comments in writing.

10.03 Response to Appeal. The Auditor-Controller, or his designee shall render a decision on review of a claim not later than *sixty (60) days* after receipt of a request for review under Section 10.02. Such decision shall be in writing and shall state the reasons for the decision, referring to the Plan or Code provisions upon which it is based. Such decision of the Auditor-Controller, shall be final and conclusive.

ARTICLE XI

PLAN ADMINISTRATOR

11.01 Plan Administrator. The "Plan Administrator" shall be the Human Resources Director of the Employer. The Plan Administrator shall have authority and responsibility to take by majority vote any reasonable actions necessary to control and manage the operation and administration of this Plan under rules applied on a uniform and nondiscriminatory basis to all Participants.

11.02 Appeals. All Appeals should be directed to the County of Santa Barbara Auditor-Controller who shall have the authority and responsibility to decide the provisions of Section 10 above.

11.03 Expenses. All reasonable expenses of the Plan Administrator shall be paid by the Employer from general funds plus forfeitures referred to in Section 9.02.

ARTICLE XII

EMPLOYER CONTRIBUTIONS

All contributions to the Plan shall be designated and deemed to be Employer contributions. These Employer contributions are made pursuant to elections made or deemed made under Article 7 which shall have the effect of Compensation Reduction Agreements between the Participants and the Employer. A separate fund or trust may (but need not) be established by the Employer as necessary to hold any contribution to be later transferred to Participants as Benefits hereunder.

ARTICLE XIII

AMENDMENT OR TERMINATION

This Plan may be amended or terminated at any time by the *Board of Supervisors* of the Employer; provided, however, that termination or amendment shall not affect the right of any Participant to claim Benefits for Eligible Expenses for Qualifying Dependent Care Services provided prior to termination or amendment, to the extent such amounts are payable under the terms of the Plan as in effect prior to the calendar month in which the Plan is terminated or amended. Any amendment or termination shall take effect only as of the end of a pay period.

ARTICLE XIV

MISCELLANEOUS

14.01 No Personal Liability. Nothing contained herein shall impose on any officers or directors of the Employer any personal liability for any Benefits due a Participant or Dependent pursuant to this Plan.

14.02 Additional Procedures. Any rules, regulations, or procedures that may be necessary for the proper administration or functioning of this Plan may be promulgated and adopted by the Plan Administrator.

14.03 Assignment and Alienation of Benefits. Benefits provided under this Plan shall not be subject to assignment or alienation.

14.04 Agreement not an Employee Contract. This Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant. This Plan shall not be deemed to give any Participant or other 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 other Employee at any time regardless of the effect which such discharge shall have upon such person as a Participant in this Plan. This Plan shall not be deemed to give the Employer the right to require any Participant or other Employee to remain in the employ of the Employer or to restrict any such person's right to terminate his employment at any time.

14.05 Severability. If any provision of this Plan shall be held invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if such illegal and invalid provisions had never been included.

14.06 Gender and Number. In the construction of this Plan, reference to any gender shall include the masculine, feminine and neuter genders, the plural shall include the singular and the singular the plural, whenever appropriate.

14.07 Construction. The terms of the Plan shall be construed under the laws of the State of California except to the extent such laws are preempted by federal law.

ARTICLE XV

ENTIRE AGREEMENT

This document sets forth the entire Plan. Except as provided in this Plan, no other employee benefit plan which is, or may hereafter be, maintained by the Employer on a non-elective basis shall constitute a part of this Plan.

COUNTY OF SANTA BARBARA

HEALTH SAVINGS ACCOUNT COMPONENT PLAN

A COMPONENT PLAN OF THE
COUNTY OF SANTA BARBARA
I.R.S. SECTION 125 PLAN

Effective July 1, 2006

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INTRODUCTION

The County of Santa Barbara (hereinafter "Employer") establishes this "County of Santa Barbara Health Savings Account Component Plan" (hereinafter the "HSA Component"), and memorializes the establishment of the HSA Component through this amendment effective July 1, 2006, to allow Eligible Employees of the Employer who establish a health savings account("HSA") to make contributions to that HSA pursuant to a Compensation Reduction Agreement.

ARTICLE I

DEFINITIONS

The definitions included in Article I of the County of Santa Barbara I.R.S. Section 125 Plan are incorporated herein in full by reference, to the extent applicable.

ARTICLE II

ELIGIBLITY AND CONDITIONS OF PARTICIPATION

To be deemed an Eligible Employee who may participate in this HSA Component Plan, an individual must satisfy the definition of Eligible Employee contained in the County of Santa Barbara I.R.S. Section 125 Plan. In addition, to be deemed an Eligible Employee the individual must also satisfy the definition of "eligible individual" contained in section 223 of the Internal Revenue Code.

Eligible Employees shall become eligible to participate in the HSA Component Plan on the first day of the pay period on or after the date of hire. Eligible Employees have 30 days from the date of hire to enroll in this Plan.

Eligible Employees must fully complete and execute a Compensation Reduction Agreement, must provide proof that the Participant has established an HSA through a trustee/custodian to which the Employer can forward contributions, must provide proof the Participant is covered under a high deductible health plan sponsored by Employer, and must provide proof of age (for catch-up contributions). These documents must be provided to the County of Santa Barbara Human Resources Department. Eligible Employees must additionally satisfy all other administrative requirements established by the Plan Administrator. Each Eligible Employee upon becoming covered by this Plan shall be deemed conclusively, for all purposes, to have assented to the terms and provisions of this Plan and shall be bound thereby.

ARTICLE III

HSA BENEFITS

An Eligible Employee may elect to participate in the HSA Component Plan by electing to make contributions on a pre-tax salary reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). Such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

HSA Benefits cannot be elected with Health Care Reimbursement Account Benefits. In addition, a Participant who has an election for Health Care Reimbursement Account Benefits that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless no amounts remain in the Participant's Health Care Reimbursement Account at the end of that Plan Year.

ARTICLE IV

CONTRIBUTIONS FOR COST OF COVERAGE FOR HSA; MAXIMUM LIMITS

The maximum annual contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant, plus any contribution which may be made by Employer. In no event shall the amount elected, plus the employer's contribution, exceed the statutory maximum amount for HSA contributions as set by the Internal Revenue Service for the calendar year in which the contribution is made. The Employer's initial contribution amount will be approximately $550 per year, which sum will be contributed in 26 equal biweekly installments throughout the Plan Year. The Employer contribution amount may be adjusted from time to time as determined by and approved by the Board of Supervisors. The Participant's contribution may also be made in 26 equal biweekly installments, or in one installment at the beginning of the Plan year.

Individuals who satisfy the eligibility requirements of this Plan after the beginning of the Plan Year are entitled to salary reduce the full maximum annual contribution allowed by law for the Plan Year, reduced by any contribution made by the Employer. The Employer's biweekly installment contributions will not increase in this event.

An additional catch-up contribution ($700 for 2006, increasing by $100 each year until $1,000 in 2009 and thereafter) may be made by Participants who are age 55 or older.

ARTICLE V

RECORDING CONTRIBUTIONS FOR HSA

As described below, the HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. However, the Employer may limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax salary reductions—such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA contributions an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

ARTICLE VI

TAX TREATMENT OF HSA CONTRIBUTIONS AND DISTRIBUTIONS

The tax treatment of the HSA (including contributions and distributions) is governed by Internal Revenue Code § 223 and state law. The tax treatment of the HSA may differ under federal and state law.

ARTICLE VII

TRUST/CUSTODIAL AGREEMENT; HSA NOT INTENDED TO BE AN ERISA PLAN

HSA Benefits under this Plan consist solely of the ability to make Contributions to an HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Internal Revenue Code § 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE VIII

MISCELLANEOUS

8.1 Administration of the HSA Component

The HSA Component shall be administered in accordance with the provisions set forth in the County of Santa Barbara I.R.S. Section 125 Plan.

8.2 Termination of the HSA Component Plan

The Employer reserves the right to amend or terminate this HSA Component Plan in whole or in part at any time, subject to Section 8.2 of the Plan.

8.3 Entire Agreement

This document sets forth the entire HSA Component Plan. Except as provided herein, no other employee benefit plan which is, or may hereafter be, maintained by the Employer on a non-elective basis shall constitute a part of this Plan.

8.4 No Personal Liability

Nothing contained herein shall impose on any officers or directors of the Employer any personal liability for any Benefits due an Eligible Employee pursuant to this HSA Component Plan.

8.5 Additional Procedures

Any rules, regulations, or procedures that may be necessary for the proper administration or functioning of this Plan may be promulgated and adopted by the Plan Administrator.

8.6 Assignment and Alienation of Benefits

Benefits provided under this Plan shall not be subject to assignment or alienation.

8.7 Agreement not an Employee Contract

This HSA Component Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant. This Plan shall not be deemed to give any Participant or other 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 other Employee at any time regardless of the effect which such discharge shall have upon such person as a Participant in this Plan. This Plan shall not be deemed to give the Employer the right to require any Participant or other Employee to remain in the employ of the Employer or to restrict any such person's right to terminate his employment at any time.

8.8 Severability

If any provision of this HSA Component Plan shall be held invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if such illegal and invalid provisions had never been included.

8.9 Gender and Number

In the construction of this HSA Component Plan, reference to any gender shall include the masculine, feminine and neuter genders, the plural shall include the singular and the singular the plural, whenever appropriate.

8.10 Construction

The terms of the HSA Component Plan shall be construed under the laws of the State of California except to the extent such laws are preempted by federal law.