

DOUGLAS COUNTY CAFETERIA PLAN ELIGIBLE OPT-OUT ARRANGEMENT

Description of Eligible Opt-Out Arrangement. Effective January 1, 2020, the Douglas County Cafeteria Plan (the "Plan") has adopted this Eligible Opt-Out Arrangement as a Benefit Option under the Plan. The Eligible Opt-Out Arrangement allows eligible Participants to decline the Plan's Health Insurance Benefit and coverage under the group medical plan(s), excluding the Central States Health Plan, for employees of Douglas County for a specified Plan Year and receive cash payments in lieu of such coverage.

The Eligible Opt-Out Arrangement requires that the cash in lieu of group medical plan coverage be available only if the Participant provides reasonable evidence of enrollment in other employer-sponsored group health coverage (such as a spouse's plan), or "minimum essential coverage" from some other source during the Plan Year, for the Participant and the Participant's expected tax dependents. Individual coverage, including insurance purchased on the ACA Exchange, will not qualify under the Eligible Opt-Out Arrangement. Coverage under government programs, such as Medicare Part A, most Medicaid, CHIP and TRICARE, can qualify if minimum essential coverage is provided to the Participant and/or expected tax dependents by the program.

The Plan's Eligible Opt-Out Arrangement is not an "employer payment plan" as such term is generally defined by the Internal Revenue Service. Any cash payments made under the Eligible Opt-Out Arrangement are not intended to provide for the direct or indirect purchase or reimbursement of any type of medical coverage, whether such coverage is provided under a group or individual policy or plan, and shall be treated as payment of unrestricted and taxable cash compensation to the Participant.

Eligibility to Participate. This Eligible Opt-Out Arrangement is available to Participants who are eligible to participate in the group medical plan(s), except the Central States Health Plan, sponsored by Douglas County for its eligible employees and dependents, but only to the extent the Participant and his or her dependents (for federal income tax purposes) have minimum essential coverage under another employer-sponsored group health plan or qualifying government program. A Participant who elects to opt-out of group medical plan coverage will be required to certify that the Participant has (or will have) other minimum essential coverage from a qualifying group health plan or government program at the time the Participant elects to participate in the Eligible Opt-Out Arrangement. To the extent the Participant elects and qualifies under the Eligible Opt-Out Arrangement, a cash payment in lieu of coverage under the group medical plan(s) will be added to the Participant's compensation, in equal payments throughout the Plan Year. Any cash payments made to a Participant under the Eligible Opt-Out Arrangement will be considered taxable income and subject to all applicable income tax withholding and employment taxes. The amount of any payments under the Eligible Opt-Out Arrangement will be determined each year at the sole discretion of Douglas County and announced during the open enrollment period for the Plan.

Election and Enrollment. Eligible Participants may elect and enroll in the Eligible Opt-Out Arrangement for a Plan Year by completing and executing the Eligible Opt-out Arrangement Election Form (attached hereto) and filing the completed Form with the Plan Administrator of the Plan on or before the Plan Year for which the opt-out election

is to be effective. In addition to the Participant's certification (in the enrollment and Election Form) that the Participant and expected tax dependents are (or will) receive minimum essential coverage from another source, the Plan Administrator may, at any time, require the Participant to submit documentary evidence of such minimum essential coverage as a condition to qualifying for the opt-out payments.

A Participant's election to participate in the Eligible Opt-Out Arrangement is irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections under the Plan (see Section 5.4 of the Plan: "Change in Status"). Accordingly, a Participant who has elected to participate in the Eligible Opt-Out Arrangement for a Plan Year must generally wait until the beginning of the next Plan Year to enroll in the group medical plan(s) sponsored for employees of Douglas County. Declining coverage under the Douglas County group medical plan(s) does not preclude the Participant from electing other Benefit Options offered under the Plan.

A Participant will no longer be eligible to receive cash payments under the Eligible Opt-Out Arrangement to the extent the Participant: 1) has terminated employment with Douglas County; 2) is no longer eligible to participate in the Plan (or no longer eligible to participate in the Douglas County group medical plan(s)); 3) enrolls in the Douglas County group medical plan(s); or 4) ceases to maintain eligible group health plan coverage or qualifying minimum essential coverage from another source. A Participant who loses coverage under the other group health plan or government program at any time during the period that the Participant has elected to receive payments under the Eligible Opt-Out Arrangement, must notify the Plan Administrator immediately. If the Participant is at any time unable to certify or provide proof to the Plan Administrator of minimum essential coverage for the Participant or his or her tax dependents, the Participant will be ineligible for continued payments under the Eligible Opt-Out Arrangement and liable to repay Douglas County any amounts that had been received for any period following the Participant's loss of eligibility under the Eligible Opt-Out Arrangement.

Administration. The Plan Administrator of the Plan shall administer and supervise the operation of the Eligible Opt-Out Arrangement and have all powers and duties as provided under the Plan as necessary or appropriate for the general administration and compliance with all requirements of the Eligible Opt-Out Arrangement.

Douglas County Cafeteria Plan
Eligible Opt-Out Arrangement Election Form

In accordance with the terms of the Douglas County Cafeteria Plan (the "Plan"), Participants in the Plan who elect not to participate in the group medical plan(s) for employees of Douglas County, and who qualify under the Plan's Eligible Opt-out Arrangement, will be entitled to receive cash payments in lieu of group medical plan coverage.

By completing this Election Form, I hereby affirm my declination of coverage under the Douglas County group medical plan(s) for myself, my spouse, and my dependents (as applicable) and instead elect to receive cash payments in lieu of coverage under the group medical plan(s) pursuant to the Eligible Opt-Out Arrangement.

Pursuant to my election, I fully understand, certify, and attest to the following:

1. I have and will maintain coverage under another group health plan or other program providing "minimal essential coverage" for the Plan Year in which this election applies for myself and my federal income tax dependents, not including coverage obtained in the individual marketplace. I agree to provide documentary evidence of such coverage immediately upon request of the Plan Administrator.
2. My election to decline coverage under the Douglas County group medical plan(s) is entirely voluntary. Neither Douglas County nor the Plan Administrator is responsible for any medical expenses of me or my dependents incurred after the termination of my participation in the Douglas County group medical plan(s). Furthermore, I understand that my covered dependents and I will not be eligible for COBRA continuation coverage under the Douglas County group medical plan(s) by reason of this election.
3. This election is effective only for the Plan Year as indicated below. If I intend to decline coverage under the Douglas County group medical plan(s) and participate in the Plan's Eligible Opt-Out Arrangement in future Plan Years, I will need to make a new election for each future Plan Year.
4. To the extent I remain eligible for participation in the Douglas County group medical plan(s) but have instead elected to participate in the Plan's Eligible Opt-Out Arrangement, I will receive equal periodic cash payments in an amount determined at the sole discretion of Douglas County and which is affirmatively communicated to the employees of Douglas County during open enrollment periods for the Plan.
5. Any cash payments I receive as a result of my election to participate in the Eligible Opt-Out Arrangement shall be taxable income to me and subject to applicable tax withholdings and employment taxes. I have fully considered, and am solely responsible for, any adverse tax consequences that may occur as a result of my election to participate in the Eligible Opt-Out Arrangement.
6. My election to decline coverage under the Douglas County group medical plan(s) and to instead elect the Eligible Opt-Out Arrangement will not preclude me from electing any other Benefit Options offered under the Plan; provided, however, the

Eligible Opt-Out Arrangement is only available with respect to the Douglas County group medical plan(s) and will not provide cash in lieu of any other Benefit available under the Plan.

7. If I terminate employment with Douglas County, enroll in any group medical plan available to employees of Douglas County, lose coverage under a qualifying group health plan, or am otherwise unable to certify or provide proof of minimum essential coverage under a qualifying group health plan or government program, I will no longer be eligible to receive payments in lieu of coverage under the Eligible Opt-Out Arrangement. If I lose coverage under the qualifying group health plan or government program, I must notify the Plan Administrator immediately. Failure to do so could result in liability to my employer for any payments made under the Eligible Opt-Out Arrangement after the loss of such coverage.
8. I agree to return all payments made to me and for which I was not eligible, including, but not limited to, payments received pursuant to my (a) failure to report a change or loss of minimal essential coverage from another source in a timely manner, or (b) falsifying information in order to receive opt-out payments. By signing this Election Form, I hereby authorize my employer, Douglas County, at its discretion, to deduct any such amounts from my pay to the extent allowable under applicable state and federal law.
9. By declining coverage under the Douglas County group medical plan(s), I am generally unable to elect to participate in the group medical plan until the next Plan Year, except in limited circumstance as set forth in the Plan. Any qualifying mid-year election under the Plan to participate in the Douglas County group medical plan(s) shall make this election null and void for the remainder of the year, and all payments to me under the Eligible Opt-Out Arrangement shall cease as of the date of coverage under such group medical plan.
10. I understand that the payments made to me pursuant to my election to participate in the Eligible Opt-Out Arrangement is unrestricted compensation to me and such payments are not intended for the reimbursement or purchase of medical coverage, whether such coverage is provided under an individual or group plan or policy.
11. I have been provided a copy of, read, and understand the Plan, the Eligible Opt-Out Arrangement and any summaries which explain the Plan and the Eligible Opt-Out Arrangement.

Plan Year of the Opt-Out Election: _____

Information about the minimal essential coverage for Participant and expected tax family*:

*The expected tax family consists of all individuals for whom the Participant reasonably expects to claim a personal exemption deduction for with respect to the applicable tax year of the opt-out election.

Name(s) of covered person(s): _____

Name of covered person's employer(s): _____

Insurer or program providing medical coverage: _____

I hereby certify that I and all members of my expected tax family are covered under another group medical plan or program providing minimum essential coverage for the Plan Year indicated above, and that I hereby decline all coverage under the Douglas County group medical plan(s), and elect to participate in the Eligible Opt-Out Arrangement for such Plan Year.

Participant's Signature: _____ **Date:** _____

Coverage Reinstatement Attestation

I previously waived coverage because I had other minimum essential coverage under a group health plan or program for myself and all my federal income tax dependents. As of _____ I am no longer covered by such group health plan or program and request to enroll in the Douglas County group medical plan. I understand that my eligibility to enroll in the Douglas County group medical plan at this time is dependent on whether I have satisfied the Plan's special conditions for midyear enrollment.

Employee Signature: _____ **Date:** _____

Return completed form to the Plan Administrator of the Douglas County Cafeteria Plan.