ALAMEDA County Transportation Commission
1111 Broadway, Suite 800, Oakland, CA 94607 • 510.208.7400 • www.AlamedaCTC.org

Finance and Administration Committee Meeting Agenda
Monday, May 10, 2021, 9:30 a.m.

Due to the statewide stay at home order and the Alameda County Shelter in Place Order, and pursuant to the Executive Order issued by Governor Gavin Newsom (Executive Order N-29-20), the Commission will not be convening at its Commission Room but will instead move to a remote meeting.

Members of the public wishing to submit a public comment may do so by emailing the Clerk of the Commission at vlee@alamedactc.org by 5:00 p.m. the day before the scheduled meeting. Submitted comments will be read aloud to the Commission and those listening telephonically or electronically; if the comments are more than three minutes in length the comments will be summarized. Members of the public may also make comments during the meeting by using Zoom's "Raise Hand" feature on their phone, tablet or other device during the relevant agenda item, and waiting to be recognized by the Chair. If calling into the meeting from a telephone, you can use "Star (*) 9" to raise/ lower your hand. Comments will generally be limited to three minutes in length, or as specified by the Chair.

Committee Chair:	Luis Freitas, City of Newark	Executive Director:	Tess Lengyel
Vice Chair:	Richard Valle, Alameda County, District 2	Staff Liaison:	Patricia Reavey
Members:	Karla Brown, Jen Cavenaugh, Melissa Hernandez	Clerk of the Commission:	Vanessa Lee
Ex-Officio:	Pauline Russo Cutter, John Bauters		

Location Information:

Virtual Meeting Information: https://zoom.us/j/96362636411?pwd=NTRRbldhTm5XSnlBZEhsMjBSWGhTdz09
Webinar ID: 963 6263 6411
Password: 461150

For Public Access Dial-in Information: **(669) 900-6833**
Webinar ID: 963 6263 6411
Password: 461150

To request accommodation or assistance to participate in this meeting, please contact Vanessa Lee, the Clerk of the Commission, at least 48 hours prior to the meeting date at: vlee@alamedactc.org

1. Call to Order

2. Roll Call

3. Public Comment

		Page	Action
4.	**Consent Calendar**		
4.1.	Approve the March 8, 2021 FAC Meeting Minutes	1	
4.2.	FY2020-21 Third Quarter Report of Claims Acted Upon Under the Government Claims Act	5	I
4.3.	2020 Alameda CTC Annual Report Update	7	I
4.4.	Approve an Update to Independent Watchdog Committee Bylaws	9	A
4.5.	Approve the Alameda CTC FY2020-21 Third Quarter Consolidated Financial Report	21	A
4.6.	Approve the Alameda CTC FY2020-21 Third Quarter Investment Report	27	A
4.7.	Approve an Update to the Alameda CTC Investment Policy	43	A
5.	**Regular Matters**		
5.1.	Approve Measure B and Measure BB Sales Tax Budget Update for FY2020-21	61	A
5.2.	Approve the Alameda CTC FY2021-22 Proposed Budget	63	A
5.3.	Approve and adopt restatements of the Alameda CTC Cafeteria Plan	71	A
6.	**Committee Member Reports**		
7.	**Staff Reports**		
8.	**Adjournment**		

Next Meeting: September 13, 2021

Notes:

- All items on the agenda are subject to action and/or change by the Commission.
- To comment on an item not on the agenda (3-minute limit), submit a speaker card to the clerk.
- Call 510.208.7450 (Voice) or 1.800.855.7100 (TTY) five days in advance to request a sign-language interpreter.
- If information is needed in another language, contact 510.208.7400. Hard copies available only by request.
- Call 510.208.7400 48 hours in advance to request accommodation or assistance at this meeting.
- Meeting agendas and staff reports are available on the website calendar.
- Alameda CTC is located near 12th St. Oakland City Center BART station and AC Transit bus lines. Directions and parking information are available online.

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Alameda CTC Schedule of Upcoming Meetings
May through June 2021

Commission and Committee Meetings

Time	Description	Date
2:00 p.m.	Alameda CTC Commission Meeting	May 27, 2021 June 24, 2021
10:00 a.m.	Programs and Projects Committee (PPC)	June 14, 2021
11:30 a.m.	Planning, Policy and Legislation Committee (PPLC)	
1:00 p.m.	Alameda CTC Audit Committee	

Advisory Committee Meetings

5:30 p.m.	Bicycle and Pedestrian Advisory Committee (BPAC)	May 27, 2021
1:30 p.m.	Alameda County Technical Advisory Committee (ACTAC)	June 10, 2021
1:30 p.m.	Paratransit Advisory and Planning Committee	June 28, 2021

Due to the statewide stay at home order and the Alameda County Shelter in Place Order, and pursuant to the Executive Order issued by Governor Gavin Newsom (Executive Order N-29-20), the Commission will not be convening at its Commission Room but will instead move to a remote meeting.

Meeting materials, directions and parking information are all available on the Alameda CTC website. Meetings subject to change.

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1. **Pledge of Allegiance**

2. **Roll Call**
   A roll call was conducted. All members were present.

3. **Public Comment**
   There were no public comments.

4. **Consent Calendar**
   4.1. Approve the November 9, 2020, FAC Meeting Minutes
   4.2. FY2020-21 Second Quarter Report of Claims Acted Upon Under the Government Claims Act
   4.3. Approve the Alameda CTC FY2020-21 Second Quarter Investment Report
   4.4. Approve the Alameda CTC FY2020-21 Second Quarter Consolidated Financial Report

   Commissioner Brown noted that she was not in attendance for the meeting and asked if she should vote on the minutes. Neal Parish, Legal Counsel, noted that Commissioner Brown can vote on this item even if she did not attend the meeting.

   Commissioner Cutter moved to approve the Consent Calendar. Commissioner Cavenaugh seconded the motion. The motion passed with the following roll call votes:

Yes:	*Bauters, Brown, Cavenaugh, Cutter, Freitas, Hernandez, Valle*
No:	*None*
Abstain:	*None*
Absent:	*None*

5. **Regular Matters**
   5.1. Approve the FY2020-21 Mid-Year Budget Update
   Tess Lengyel noted that each spring the agency provides the Commission with a budget update to address changes in revenues and expenditures over the year. Ms. Lengyel introduced Patricia Reavey, Deputy Executive Director of Finance, and Jeannie Chen, Director of Finance, to present the item. Ms. Reavey recommended that the Commission approve the FY2020-21 mid-year update. She noted that this update to the budget reflects an increase in the beginning fund balance based on the audited financial statements in the Comprehensive Annual Financial Report for the Year Ended June 30, 2020; an update to revenues and expenditures to reflect the change in needs since the FY2020-21 budget was adopted in May 2020; and

includes the allowance for a short-term, inter-fund loan of up to $125 million from the 1986 Measure B program to the 2014 Measure BB Capital program that would delay the need for external financing until FY2022-23. Ms. Reavey stated that the sales tax revenues have not been adjusted in this update to the budget, but will be when data is received from the California Department of Tax and Fee Administration (CDTFA). She noted that an update to the sales tax revenues budget is expected to come to the Commission for approval in May 2021, after the agency has received at least two full quarters of data from the CDTFA. Ms. Reavey reviewed proposed reserve levels in the proposed budget and concluded that the proposed update to the FY2020-21 budget will provide resources of $404.3 million; authorized expenditures of $616.7 million for an overall decrease in fund balance of $212.4 million and a projected ending fund balance of $366.3 million.

Commissioner Brown asked how sales tax was adjusted and how it has been affected by hotel taxes. Ms. Reavey stated that changes to the sales tax revenues budget was not proposed in this budget update. She stated that the sales tax revenue budget is expected to be updated in May 2021 and she noted that hotel taxes do not affect sales tax revenues. Ms. Reavey stated that while the Alameda CTC is not at its record high sales tax revenue collection level that was projected before the pandemic hit, the agency is not falling as far behind as originally anticipated.

Commissioner Brown asked if Alameda CTC has a repair and replacement percentage that will be used as a guideline for budgetary items. Ms. Reavey stated that the repair and replacement would generally affect the operations on the I-580 Express Lanes. She noted that the agency has set aside a $5 million reserve for maintenance on the I-580 Express Lanes which is adjusted as needed based on projected maintenance needs.

Commissioner Cavenaugh wanted to confirm that the downside projected during the prior year is already reflected in the numbers, so any changes that are foreseen going forward with the sales tax revenue budget would potentially be on the upside in the current budget. Ms. Reavey stated that she expects the update to the sales tax revenues budget to be an upward adjustment.

Commissioner Cavenaugh wanted clarification on what is driving the delta between the expenditures and revenues. Ms. Reavey stated that the agency sees a decrease in the net change in fund balance that is directly related to the roll-over of capital budget authority from the prior fiscal year.

Commissioner Cutter asked if the agency has seen a decrease in people paying their registration fees during the pandemic. Ms. Reavey stated that Alameda CTC does not see the registration fees; however, the agency sees the sales tax for the add-on program. She noted that the Governor delayed payment of registration fees until

November 2020 and Alameda CTC did not see a large jump to account for businesses making up for having delayed their payments.

Commissioner Bauters moved to approve this item. Commissioner Brown seconded the motion. The motion passed with the following votes:

Yes:	*Bauters, Brown, Cavenaugh, Cutter, Freitas, Hernandez, Valle*
No:	*None*
Abstain:	*None*
Absent:	*None*

6. Committee Member Reports

Commissioner Freitas welcomed Commissioners Brown, Cavenaugh, and Hernandez to the FAC committee.

7. Staff Reports

Ms. Lengyel stated that at the end of February, Alameda CTC received a reaffirmation by Fitch Ratings on the agency's AAA rating. She expressed her appreciation to the Commission and Alameda CTC's Finance Department.

Ms. Lengyel stated that Alameda CTC's partners are implementing Alameda CTC's quick build projects, which include approximately $2 Million of investments by March 31, 2021.

8. Adjournment/ Next Meeting

The next meeting is:

Date/Time: Monday, May 10, 2021 at 9:30 a.m.

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DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM	Patricia Reavey, Deputy Executive Director of Finance and Administration
SUBJECT:	FY2020-21 Third Quarter Report of Claims Acted Upon Under the Government Claims Act

Recommendation

This item is to provide the Commission with an update on the FY2020-21 Third Quarter Report of Claims Acted upon under the Government Claims Act. This item is for information only.

Summary

There were no actions taken by staff under the Government Claims Act during the third quarter of FY2020-21.

Background

Tort claims against Alameda CTC and other California government entities are governed by the Government Claims Act (Act). The Act allows the Commission to delegate authority to an agency employee to review, reject, allow, settle, or compromise tort claims pursuant to a resolution adopted by the Commission. If the authority is delegated to an employee, that employee can only reject claims or allow, settle, or compromise claims $50,000 or less. The decision to allow, settle, or compromise claims over $50,000 must go before the Commission for review and approval.

California Government Code section 935.4 states:

> "A charter provision, or a local public entity by ordinance or resolution, may authorize an employee of the local public entity to perform those functions of the governing body of the public entity under this part that are prescribed by the local public entity, but only a charter provision may authorize that employee to allow, compromise, or settle a claim against the local public entity if the amount to be paid pursuant to the allowance, compromise or

settlement exceeds fifty thousand dollars ($50,000). A Charter provision, ordinance, or resolution may provide that, upon the written order of that employee, the auditor or other fiscal officer of the local public entity shall cause a warrant to be issued upon the treasury of the local public entity in the amount for which a claim has been allowed, compromised, or settled."

On June 30, 2016, the Commission adopted a resolution which authorized the Executive Director to reject claims or allow, settle, or compromise claims up to and including $50,000.

There have only been a handful of small claims filed against Alameda CTC and its predecessors over the years, and many of these claims were erroneously filed, and should have been filed with other agencies. As staff moves forward with the implementation of Measure BB, Alameda CTC may experience an increase in claims against the agency as Alameda CTC puts more projects on the streets and highways of Alameda County and as Alameda CTC's name is recognized as a funding agency on these projects. Staff works directly with the agency's insurance provider, the Special District Risk Management Authority (SDRMA), when claims are received so that responsibility may be determined promptly and they might be resolved expediently or referred to the appropriate agency. This saves Alameda CTC money because when working with the SDRMA directly, much of the legal costs to address these claims are covered by insurance.

Fiscal Impact: There is no fiscal impact. This is an information item only.

DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Administration Carolyn Clevenger, Deputy Executive Director of Planning and Policy
SUBJECT:	2020 Alameda CTC Annual Report Update

Recommendation

This item is to inform the Commission that the 2020 Alameda CTC Annual Report has been prepared and completed for distribution. This item is for information only.

Summary

Alameda CTC prepares an annual report each year, as required in the Public Utilities Code section 180111, on progress made to achieve the objective of improving transportation in Alameda County. The 2020 Annual Report highlights key transportation programs and projects that Alameda CTC plans, funds, and delivers and includes financial information for FY 2019-20.

Many of these transportation investments are funded largely through local, voter-approved Measure B and Measure BB sales tax dollars and local, voter-approved Vehicle Registration Fee (VRF) funds. The annual report includes financial information related to Measure B and Measure BB revenues and expenditures for the year ended June 30, 2020, as well as information related to the VRF Program, including the total net VRF revenue from the start of the program, and revenues and expenditures through June 30, 2020.

Fiscal Impact: There is no fiscal impact. This is an information item only.

Attachment:

A. Draft 2020 Alameda CTC Annual Report

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DATE:	Mary 3, 2021
TO:	Finance and Administration Committee
FROM	Patricia Reavey, Deputy Executive Director of Finance and Administration
SUBJECT:	Approve an update to Independent Watchdog Committee Bylaws

Recommendation

Staff is recommending approval of an update to the Independent Watchdog Committee (IWC) bylaws, attached in redline, as proposed by the IWC.

Summary

Alameda CTC's Independent Watchdog Committee (IWC) reviewed the bylaws of their committee during their March 8, 2021 meeting and have proposed some minor edits. Staff has modified the currently adopted IWC bylaws in the attached redlined version to incorporate the edits suggested by the IWC.

Per Article 5.1 of the Commission's Administrative Code, the Commission is responsible for adopting and amending the bylaws for the IWC, as deemed necessary. Staff does not foresee any issues with the edits proposed by the IWC, which are administrative in nature, and recommends approval by the Commission of the updates to the IWC bylaws as outlined in Attachment A.

Background

The Independent Watchdog Committee (IWC) as defined in the 2014 Transportation Expenditure Plan (TEP), is the same committee as the Citizens Watchdog Committee, as defined in the 2000 TEP. The required composition of the IWC is defined in the 2000 and 2014 TEPs. The IWC, is a 17-member committee that reports directly to the public and is charged with reviewing all Measure B expenditures and reviewing Measure BB expenditures and performance measures, as appropriate. The members are Alameda County residents who are not elected officials at any level of government, nor individuals in a position to benefit personally in any way from the sales taxes.

Fiscal Impact: There is no fiscal impact related to the approval of this item.

Attachment

A. Independent Watchdog Committee Bylaws (redlined)

ALAMEDA County Transportation Commission
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Independent Watchdog Committee Bylaws

Article 1: Definitions

1.1 2000 Transportation Expenditure Plan. The plan for expending transportation sales tax (Measure B) funds, presented to the voters in 2000, and implemented in 2002.

1.2 2014 Transportation Expenditure Plan. The plan for expending transportation sales tax (Measure BB) funds, presented to the voters in 2014, and implemented in 2015.

1.3 Agency. A business or government organization established to provide a particular service.

1.4 Alameda County Transportation Commission (Alameda CTC). Alameda CTC is a joint powers authority resulting from the merger of the Alameda County Congestion Management Agency ("ACCMA") and the Alameda County Transportation Improvement Authority ("ACTIA"). The 22-member Alameda CTC Commission ("Commission") is comprised of the following representatives:

1.4.1 All five Alameda County Supervisors.

1.4.2 Two City of Oakland representatives.

1.4.3 One representative from each of the other 13 incorporated cities in Alameda County.

1.4.4 A representative from Alameda-Contra Costa Transit District ("AC Transit").

1.4.5 A representative from San Francisco Bay Area Rapid Transit District ("BART").

1.5 Alameda County Transportation Improvement Authority (ACTIA). The governmental agency previously responsible for the implementation of the Measure B half-cent transportation sales tax in Alameda County, as approved by voters in 2000 and implemented in 2002. Alameda CTC has now assumed responsibility for administration of the sales tax.

1.6 Appointing Party. A person or group designated to appoint committee members.

1.7 At-Large Member. One of the 10 Independent Watchdog Committee (IWC) members representing supervisorial districts as described in Section 3.1.1 below.

1.8 Bicycle and Pedestrian Advisory Committee (BPAC). The Alameda CTC Committee that involves interested community members in the Alameda CTC's policy, planning, and implementation efforts related to bicycling and walking.

1.9 Brown Act. California's open meeting law, the Ralph M. Brown Act, California Government Code, Sections 54950 *et seq.*

1.10 Expenditures. Costs incurred and paid for with funds generated from the Measure B and Measure BB sales taxes.

1.11 Fiscal Year. July 1 through June 30.

1.12 Independent Watchdog Committee (IWC or "Committee"). The Alameda CTC Committee of individuals created by the Commission as required by Measure BB. This Committee was originally created by the ACTIA Board and called the Citizens Watchdog Committee as required by Measure B, and was continued by the Commission subsequent to the passage of Measure BB as the Independent Watchdog Committee. The Committee has the same composition as the Citizens Watchdog Committee required by Measure B. The Committee reports directly to the public and has the responsibility of reviewing all Measure B expenditures and reviewing and overseeing all Measure BB expenditures and performance measures of the agency, as appropriate. IWC members are Alameda County residents who are not elected officials at any level of government, nor individuals in a position to benefit personally in any way from the sales tax.

1.13 Local Newspapers. Periodical publications typically published weekly or daily that serve~~s~~ a city, cities or unincorporated communities within Alameda County, whereby the contents are reasonably accessible to the public. On-line publications of these periodicals are included in this definition.

1.14 Measure B. The measure approved by the voters authorizing the half-cent sales tax for transportation services now collected and administered by the Alameda CTC and governed by the 2000 Transportation Expenditure Plan. Collections for the sales tax authorized by Measure B began on April 1, 2002 and extends through March 31, 2022.

1.15 Measure BB. The measure approved by the voters authorizing the sales tax for transportation services collected and administered by the Alameda CTC and governed by the 2014 Transportation Expenditure Plan. Measure BB augments the half-cent Measure B sales tax by a half cent, beginning April 1, 2015 through March 31, 2022. The full one-cent sales tax authorized by Measure BB will begin April 1, 2022 and will extend through March 31, 2045.

1.16 Measure B Program. Transportation or transportation-related program specified in the 2000 Transportation Expenditure Plan for funding transportation programs and projects on a percentage-of-revenues or grant allocation basis.

1.17 Measure BB Program. Transportation or transportation-related program specified in the 2014 Transportation Expenditure Plan for funding transportation programs and projects on a percentage-of-revenues or grant allocation basis.

1.18 Measure B Project. Transportation and transportation-related capital projects specified in the 2000 Transportation Expenditure Plan for funding in the amounts allocated in the 2000 Transportation Expenditure Plan.

1.19 Measure BB Project. Transportation and transportation-related capital projects specified in the 2014 Transportation Expenditure Plan for funding in the amounts allocated in the 2014 Transportation Expenditure Plan.

1.20 Monitor. To observe, track, or keep a record of Measure projects, programs, and expenditures.

1.21 Organizational Meeting. An organizational meeting of the IWC will be held in July to elect officers and adopt the annual calendar/work plan and review the Alameda CTC budget related to IWC.

1.22 Organizational Member. One of the seven IWC members representing organizations as described in Section 3.1.2 below.

1.23 Oversee. To watch over Measure BB expenditures and performance measures.

1.24 Paratransit Advisory and Planning Committee (PAPCO). The Alameda CTC Committee that meets to address funding, planning, and coordination issues regarding paratransit services in Alameda County. Members must be Alameda County residents and eligible users of any transportation service available to seniors and people with disabilities in Alameda County. PAPCO is supported by a Paratransit Technical Advisory Committee comprised of Measure B and Measure BB-funded paratransit providers in Alameda County.

1.25 Performance Measures. Quantifiable methods, adopted by the Commission, used to assess how well the Alameda CTC is achieving its adopted objectives for Measure BB projects and programs.

1.26 Planning Area. Geographic groupings of cities and Alameda County for planning and funding purposes. North County: Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont; Central County: Hayward, San Leandro, unincorporated county (near Hayward); South County: Fremont, Newark, Union City; East County: Dublin, Livermore, Pleasanton, the unincorporated area of Sunol.

1.27 Subcommittee. A subset of the IWC, less than a quorum, usually organized for a certain purpose.

Article 2: Purpose and Responsibilities

2.1 Committee Purpose. The Committee is appointed pursuant to Measure B and Measure BB: 1) ~~t~~To review all expenditures of the Measure B transportation sales tax; ~~and~~ 2) to review and oversee all expenditures and performance measures, as appropriate, of the Measure BB transportation sales tax;~~,~~ 3) to monitor Measure B and Measure BB funded projects and programs; and 4) to report directly to the public.

2.2 Committee Roles and Responsibilities from Expenditure Plan. As defined by the Measure B and Measure BB Transportation Expenditure Plans, the roles and responsibilities of the Committee include:

2.2.1 Hold public hearings and issue reports, on at least an annual basis, to inform Alameda County residents about how the sales tax funds are being spent. The hearings will be open to the public and must be held in compliance with the Brown Act, California's open meeting law, with information announcing the hearings well-publicized and posted in advance.

2.2.2 Have full access to Alameda CTC's independent auditor and have the authority to request and review specific information regarding use of the sales tax funds and to comment on the auditor's reports.

2.2.3 Publish an independent annual report, including any concerns the committee has about audits it reviews. The report will be published in local newspapers and will be made available to the public in a variety of forums to ensure access to this information.

2.2.4 Provide a balance of viewpoints, geography, age, gender, ethnicity and income status, to represent the different perspectives of the residents of the county.

2.3 Additional Responsibilities. Additional IWC member responsibilities are to:

2.3.1 Communicate from time to time to the Alameda CTC by resolution, suggestions and concerns pertinent to the administration and expenditure of Measure B and Measure BB funds.

2.3.2 Communicate as necessary to recommend that an appointing party appoint a new member when there is a vacancy or upcoming end of term.

Article 3: Members

3.1 Number of Members. The IWC will consist of 17 members.

3.1.1 Ten members shall be at-large, two each representing the five supervisorial districts in Alameda County, one of the two nominated by a member of the Board of Supervisors and one of the two selected by the Alameda County Mayors' Conference.

3.1.2 Seven of the members shall be nominated by the seven organizations specified in the 2014 Transportation Expenditure Plan: East Bay Economic Development Alliance; Alameda County Labor Council; Alameda County Taxpayers' Association; Alameda County Paratransit Advisory and Planning Committee; Bike East Bay, formerly known as East Bay Bicycle Coalition; League of Women Voters; and Sierra Club.

3.2 Appointment. The Commission will make appointments in the following manner:

3.2.1 Each member of the Alameda County Board of Supervisors shall select one At-Large Member to represent his or her supervisorial district.

3.2.2 The Alameda County Mayors' Conference shall select one At-Large Member to represent each of the five supervisorial districts.

3.2.3 Each organization listed in Section 3.1.2 above shall, subject to approval by the Commission, select one organizational member.

3.3 Membership Qualification. Each IWC member shall be an Alameda County resident. An IWC member shall not be an elected official at any level of government; or be a public employee of any agency that oversees or benefits from the proceeds of Measure B and Measure BB transportation sales taxes; or have any economic interest in any project or program.

3.4 Membership Term. Appointments for at-large members shall be for two-year terms. There is no maximum number of terms a member may serve. Members may serve until the Commission appoints their successor.

3.5 Attendance. Members will regularly attend meetings. Accordingly, more than three consecutive absences is cause for removal from the Committee.

3.6 Termination. A member's term shall terminate on the occurrence of any of the following:

3.6.1 The member voluntarily resigns by written notice to the chair or Alameda CTC staff.

3.6.2 The member fails to continue to meet the qualifications for membership, including attendance requirements.

3.6.3 The member becomes incapable of continuing to serve.

3.6.4 The appointing party or the Commission removes the member from the Committee.

3.7 Vacancies. An appointing party shall have the right to appoint (subject to approval by the Commission) a person to fill the vacant member position. Alameda CTC shall be responsible for notifying an appointing party of such vacancy and for urging expeditious appointment of a new member, as appropriate.

Article 4: Officers

4.1 Officers. The IWC shall annually elect a chair and vice chair. Each officer must be a duly appointed member of the IWC.

4.1.1 Duties. The chair shall preside at all meetings and will represent the IWC before the Commission to report on IWC activities. The chair shall serve as a voting ex-officio

member of all subcommittees except a nominating subcommittee (when the IWC discusses the chair position). The vice chair shall assume all duties of the chair in the absence of, or on the request of the chair.

4.2 Office Elections. Officers shall be elected by the members annually at the Organizational Meeting or as necessary to fill a vacancy. An individual receiving a majority of votes by a quorum shall be deemed to have been elected and will assume office at that~~e~~ meeting following the election. In the event of multiple nominations, the vote shall be by ballot. Officers shall be eligible for re-election indefinitely.

Article 5: Meetings

5.1 Open and Public Meetings. All IWC meetings shall be open and public and governed by the Brown Act. Public comment shall be allowed at all IWC meetings. The time allotted for comments by a member of the public in the general public comment period or on any agenda item shall be up to 3 minutes per speaker at the discretion of the chair. Written comments may be submitted prior to the meeting. The number of IWC meetings, including regular meetings, sub-committee meetings, special meetings and public hearings, will be limited to the number of meetings approved in Alameda CTC's annual overall work program and budget, as approved by the Commission.

5.2 Regular Meetings. The IWC shall have a regular meeting at least once per quarter. Prior to each Organizational Meeting, the outgoing chair shall cause all members to be canvassed as to their available meeting times and shall recommend the day and time that best accommodates the schedules of all members, giving due regard to accommodating the schedule of any continuing member who has missed meetings due to a conflict in the prior year. Annually, at the Organizational Meeting, IWC shall establish the schedule of regular meetings for the ensuing year. Meeting dates and times may be changed and additional regular meetings scheduled during the year by action of the IWC.

5.3 Quorum. For purposes of decision making, a quorum shall consist of at least half (50 percent) plus one of the total number of members appointed at the time a decision is made. Members will not take actions at meetings with less than 50 percent plus one members present. Items may be discussed and information may be distributed on any item even if a quorum is not present; however, no action can be taken, until the Committee achieves a quorum.

5.4 Special Meetings. Special meetings may be called by the chair or by a majority of the members requesting the same in writing given to the chair, with copies to the vice chair and the Executive Director, specifying the matters to be considered at the special meeting. The chair or vice chair shall cause notice of a special meeting stating the matters to be considered to be given to all IWC members and posted and published in accordance with the Brown Act.

5.5 Public Hearing. At least annually, prior to publication of IWC's annual report, IWC shall conduct a public hearing on a draft of the IWC annual report. Each public hearing shall be conducted as part of a regular meeting.

5.6 Agenda. All meetings shall have a published agenda. Items for a regular meeting agenda may be submitted by any member to the chair and Alameda CTC staff. The Commission and/or Alameda CTC staff may also submit items for the agenda. Agenda planning meetings are held approximately three weeks prior to each IWC meeting. Alameda CTC staff will notify all IWC members when this meeting is established and remind members to submit any agenda item requests to the chair at least one day prior to the agenda planning meeting date. At the agenda planning meeting, the chair and Alameda CTC staff will discuss any agenda items submitted to the chair. Every agenda shall include a provision for members of the public to address the Committee. The chair and the vice chair shall review the agenda in advance of distribution. Copies of the agenda, with supporting material and the past meeting minutes, shall be mailed to members and any other interested parties who request it. The agenda shall be posted on the Alameda CTC website and in the Alameda CTC office and provided at the meeting, all in accordance with the Brown Act.

5.7 Roberts Rules of Order. The rules contained in the latest edition of "Roberts Rules of Order Newly Revised" shall govern the proceedings of the IWC and any subcommittees thereof to the extent that the person presiding over the proceeding determines that such formality is required to maintain order and make process, and to the extent that these actions are consistent with these bylaws.

5.8 Place of Meetings. IWC meetings shall be held at the Alameda CTC offices, unless otherwise designated by the Committee. Meeting locations shall be within Alameda County, accessible in compliance with the Americans with Disabilities Act of 1990 (41 U.S.C., Section 12132) or regulations promulgated thereunder, shall be accessible by public transportation, and shall not be in any facility that prohibits the admittance of any person, or persons, on the base of race, religious creed, color, national origin, ancestry, or sex, or where members of the public may not be present without making a payment or purchase.

5.9 Meeting Conduct. IWC members shall conduct themselves during meetings in a manner that encourages respectful behavior and provides a welcoming and safe environment for each member and staff member characterized by an atmosphere of mutual trust and respect. Members shall work with each other and staff to respectfully, fairly, and courteously deal with conflicts if they arise.

Article 6: Subcommittees

6.1 Establishment. The IWC may establish subcommittees when advisable and as necessary subject to the approved Alameda CTC overall work program and budget as approved by the Commission to conduct an investigation or to draft a report or other document within the authority of the IWC or for other purposes within the IWC's authority.

6.2 Membership. IWC members will be appointed to subcommittees by the IWC or by the chair. No subcommittee shall have fewer than three members, nor will a subcommittee have sufficient members to constitute a quorum of the IWC.

Article 7: Records and Notices

7.1 Minutes. Minutes of all meetings, including actions and the time and place of holding each meeting, shall be kept on file at the Alameda CTC office. Alameda CTC staff will prepare and include full minutes in meeting packets prior to each regular IWC meeting.

7.2 Attendance Roster. A member roster and a record of member attendance shall be kept on file at the Alameda CTC office.

7.3 Brown Act. All meetings of the IWC will comply with the requirements of the Brown Act. Notice of meetings and agendas will be given to all members and any member of the public requesting such notice in writing and shall be posted at the Alameda CTC office at least 72 hours prior to each meeting. Members of the public may address the IWC on any matter not on the agenda and on each matter listed on the agenda, in compliance with the Brown Act and time limits, up to three minutes per speaker, set at the discretion of the chair.

7.4 Meeting Notices. Meeting notices shall be in writing and shall be issued via U.S. Postal Service, Alameda CTC website, personal delivery, and/or email. Any other notice required or permitted to be given under these bylaws may be given by any of these means.

Article 8: General Matters

8.1 Per Diems. Committee members shall be entitled to a per diem stipend for meetings attended in amounts and in accordance with policies established by the Alameda CTC.

8.2 Conflicts of Interest. A conflict of interest exists when any Committee member has, or represents, a financial interest in the matter before the Committee. Such direct interest must be significant or personal. In the event of a conflict of interest, the Committee member shall declare the conflict, recuse himself or herself from the discussion, and shall not vote on that item. Failure to comply with these provisions shall be grounds for removal from the Committee.

8.3 Amendments to Bylaws. These bylaws will be reviewed annually, and may be amended, repealed, or altered, in whole or in part, by a vote taken at a duly constituted Committee meeting at which a quorum is present, as a recommendation to the Commission for approval.

8.4 Public Statements. No member of the Committee may make public statements on behalf of the Committee without authorization by affirmative vote of the Committee, except the chair, or in his or her place the vice chair, when making a regular report of the Committee activities and concerns to the Alameda CTC. This does not include presentations about the Committee to city councils, which all Committee members have a responsibility to make.

8.5 Conflict with Governing Documents. In the event of any conflict between these bylaws and the July 2000 Transportation Expenditure Plan, the January 2014 Transportation Expenditure Plan, California state law, or any action lawfully taken by ACTIA or the Alameda CTC, the Transportation Expenditure Plans, state law or the lawful action of ACTIA or the Alameda CTC shall prevail.

8.6 Staffing. Alameda CTC will provide staffing to the Committee including preparation and distribution of meeting agendas, packets, and minutes; tracking of attendance; and stipend administration.

8.7 Economic Interest. Each Committee member shall, no later than March 15 of every year, prepare and file with Alameda CTC a statement of economic interest in the form required by law, currently Form 700 which can be found on the California Fair Political Practices Commission website, http://www.fppc.ca.gov/index.php?id=500.

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DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance & Administration Yoana Navarro, Accounting Manager
SUBJECT:	Approve the Alameda CTC FY2020-21 Third Quarter Consolidated Financial Report

Recommendation

It is recommended that the Commission approve the Alameda CTC FY2020-21 Third Quarter Consolidated Financial Report.

Summary

Alameda CTC's expenditures through March 31, 2021 are within year-to-date budget authority per the currently adopted budget. The agency remains in a strong financial position compared to budget through the third quarter of FY2020-21.

The attached FY2020-21 Third Quarter Financial Report has been prepared on a consolidated basis and is compared to the currently adopted budget on a year-to-date basis. This report provides a summary of FY2020-21 actual revenues and expenditures through March 31, 2021. Variances from the year-to-date budget are demonstrated as a percentage of the budget used by line item as well as stating either a favorable or unfavorable variance in dollars. Percentages over 100 percent indicate that actual revenue or expenditure items are more than 75 percent of the total annual budget through the third quarter of the fiscal year, and percentages under 100 percent indicate that actual revenue or expenditure items are less than 75 percent of the total annual budget through the third quarter of the fiscal year. As of March 31, 2021, Alameda CTC activity for the fiscal year results in a net increase in fund balance in the amount of $35.3 million. While various funds saw an increase in their fund balances, the most significant contributors were the 2000 Measure B Capital Projects Fund and the 2014 Measure BB Special Revenue Fund which both collected sales tax revenues that outpaced expenditures during the fiscal year.

Background

The following are highlights of actual revenues and expenditures compared to budget as of March 31, 2021 by major category:

Revenues
Sales tax revenues are over budget by $23.8 million, or 11.0 percent, and investment income is over budget by $1.9 million or 61.2 percent primarily due to an adjustment to the budget to account for a decrease in market returns in the second half of the fiscal year. Grant revenues are under budget by $51.9 million mostly related to timing on capital projects. Grant revenues are recognized on a reimbursement basis and, therefore, correlate directly with related expenditures. Consequently, capital and other project expenditures are also under budget.

Salaries and Benefits
Salaries and benefits are under budget by $0.1 million, or 1.8 percent, as of March 31, 2021.

Administration
Costs for overall administration are over budget by $4.2 million, or 15.6 percent, mainly due to debt service costs which incurred 100 percent of the annual costs by March 31, 2021 compare to 75 percent of the total annual budget amount. Debt service costs are required to be recorded when incurred per government accounting standards. No additional debt service costs will be incurred in the fourth quarter, and actual expenditures in the debt service fund will equal 100% of the budget by the end of the fiscal year.

Freeway Operations
Freeway Operations expenditures are under budget by $2.0 million, or 38.4 percent, primarily related to operations and maintenance costs.

Planning
Planning expenditures are slightly over budget by $0.03 million, or 4.3 percent, related to salaries and benefits.

Programs
Programs expenditures are over budget by $5.0 million or 3.7 percent, mostly due to an increase in expenditures for Measure B and Measure BB direct local distributions (DLD) which is directly related to sales tax revenues coming in higher than projected.

Capital Projects
Capital Projects expenditures are under budget by $225.6 million, or 76.4 percent. This variance is due, in part, to prolonged right-of-way acquisition negotiations resulting in project construction delays. Alameda CTC utilizes a rolling capital budget system in which any unused approved budget from prior years is available to pay for costs in subsequent fiscal years. Additional budget authority is requested by project only as needed in accordance with the budget process. The year-to-date budget amount used for comparisons is a straight-line amortization of the total approved project budget including unspent budget authority rolled over from the prior year. Expenditures planned

through March 31, 2021 in the budget process generally will differ from the straight-line budgeted amount used for this financial statement comparison. However, presenting the information with this comparison helps financial report users, project managers, and the project control team review year-to-date expenditures to give them an idea of how projects are progressing as compared to the approved budget. There are currently no real budget issues on capital projects.

Limitations Calculations
Staff has completed the limitation calculations required in both the 2000 Measure B and 2014 Measure BB Transportation Expenditure Plans related to salary and benefits and administration costs, and Alameda CTC is compliant with all limitation requirements.

Fiscal Impact: There is no fiscal impact associated with the requested action.

Attachment:

A. Alameda CTC Consolidated Revenues/Expenditures as of March 31, 2021

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ALAMEDA COUNTY TRANSPORTATION COMMISSION
Consolidated Revenues/Expenditures
March 31, 2021

	YTD Actuals	YTD Budget	% Used	Favorable (Unfavorable)/ Variance
REVENUES				
Sales Tax Revenue	$ 241,330,090	$ 217,500,000	110.96	$ 23,830,090
Investment Income	4,890,417	3,033,750	161.20	1,856,667
Member Agency Fees	1,143,117	1,143,117	100.00	-
VRF Funds	9,804,631	9,000,000	108.94	804,631
TFCA Funds	1,545,481	1,558,892	99.14	(13,411)
Toll Revenues	6,186,250	5,250,000	117.83	936,250
Toll Violation and Penalty Revenues	1,999,661	1,125,000	177.75	874,661
Other Revenues	1,073	-	-	1,073
Regional/State/Federal Grants	9,796,249	54,707,402	17.91	(44,911,153)
Local and Other Grants	2,853,875	9,890,040	28.86	(7,036,165)
Total Revenues	$ 279,550,844	$ 303,208,201	92.20	$ (23,657,357)
EXPENDITURES				
Administration				
Salaries and Benefits [1]	$ 2,017,121	$ 2,129,225	94.73	$ 112,104
General Office Expenses	1,278,100	1,683,892	75.90	405,792
Travel Expense	4,806	7,500	64.08	2,694
Debt Service [2]	26,470,200	19,852,650	133.33	(6,617,550)
Professional Services	1,282,004	2,758,376	46.48	1,476,372
Commission and Community Support	139,382	171,956	81.06	32,574
Contingency	-	375,000	-	375,000
Subtotal	31,191,613	26,978,599	115.62	(4,213,014)
Freeway Operations				
Salaries and Benefits [1]	162,038	222,528	72.82	60,490
Operating Expenditures	3,005,203	4,640,655	64.76	1,635,452
Special Project Expenditures	-	281,250	-	281,250
Subtotal	3,167,241	5,144,433	61.57	1,977,192
Planning				
Salaries and Benefits [1]	780,173	747,700	104.34	(32,473)
Subtotal	780,173	747,700	104.34	(32,473)
Programs				
Salaries and Benefits [1]	1,824,943	1,591,042	114.70	(233,901)
Programs Management and Support	865,534	2,332,379	37.11	1,466,845
Safe Routes to School Program	1,268,905	2,265,794	56.00	996,889
VRF Programming	6,838,650	7,656,000	89.32	817,350
Measure B/BB Direct Local Distribution	124,692,009	112,386,808	110.95	(12,305,201)
Grant Awards	3,305,334	5,785,500	57.13	2,480,166
TFCA Programming	474,164	1,833,255	25.86	1,359,091
Exchange Fund Programming	16,663	415,275	4.01	398,612
Subtotal	139,286,202	134,266,053	103.74	(5,020,149)
Capital Projects				
Salaries and Benefits [1]	873,925	1,071,615	81.55	197,690
Capital Project Expenditures	68,953,648	294,318,862	23.43	225,365,214
Subtotal	69,827,573	295,390,477	23.64	225,562,904
Total Expenditures	$ 244,252,802	$ 462,527,262	52.81	$ 218,274,460
Net Change in Fund Balance	$ 35,298,042	$ (159,319,061)		
Beginning Fund Balance	578,707,927	578,707,927		
Ending Fund Balance	$ 614,005,969	$ 419,388,866		

(1) Salaries and benefits are under budget by $103,910 or 1.8% as of March 31, 2021.

(2) Debt service cost are required to be recorded when incurred per government accounting standards and will equal budget by year end.

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DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Administration Lily Balinton, Principal Financial Analyst
SUBJECT:	Approve the Alameda CTC FY2020-21 Third Quarter Investment Report

Recommendation

It is recommended that the Commission approve the Alameda CTC FY2020-21 Third Quarter Investment Report.

Summary

Alameda CTC's investments for the third quarter were in compliance with the Agency's investment policy, and the Agency has sufficient cash flow to meet expenditure requirements over the next six months.

The Consolidated Investment Report as of March 31, 2021 (Attachment A) provides balance and average return on investment information for all investments held by Alameda CTC at the end of the third quarter of fiscal year 2020-21. The report also shows balances as of June 30, 2020 for comparison purposes. The *Portfolio Review for the Quarter Ending March 31, 2021* (Attachment B), prepared by Public Trust Advisors, provides a review and outlook of market conditions and information regarding investment strategy, portfolio allocation, compliance, and returns by portfolio compared to the benchmarks.

Background

The following are highlights of key investment balance information as of March 31, 2021 compared to prior year-end balances:

- The 1986 Measure B investment balance increased by $1.8 million or 1.3 percent related to investment earnings.
- The 2000 Measure B investment balance increased $3.3 million or 1.7 percent due to 2000 Measure B sales tax collections outpacing expenditures in the capital projects fund which was offset by a decrease in the bond fund

balances as principal and interest debt service payments were made on March 1.

- The 2014 Measure BB investment balance decreased $12.8 million or 8.0 percent due to payments for Measure BB capital project expenditures outpacing sales tax revenues through the end of the third quarter of the fiscal year as progress on Measure BB projects moves forward.
- The Non-Sales Tax investment balance increased $11.1 million or 9.3 percent mostly related to deferred expenditures and deferred revenues received for projects and programs.

Investment yields have decreased from last fiscal year with an approximate average return on investments of 1.1 percent through March 31, 2021 compared to the prior fiscal year's average return of 2.1 percent. Projected return on investments for most funds was adjusted in the mid-year budget update for the FY2020-21 budget year to approximately 0.7 percent as interest rates continue to decline.

Fiscal Impact: There is no fiscal impact associated with the requested action.

Attachments:

A. Consolidated Investment Report as of March 31, 2021
B. Portfolio Review for Quarter Ending March 31, 2021 (provided by Public Trust Advisors)
C. Holdings by Security Type as of March 31, 2021

Alameda CTC
Consolidated Investment Report
As of March 31, 2021

1986 Measure B	Un-Audited	Interest Earned				FY 2019-2020	
		As of March 31, 2021				Investment Balance	Interest earned
	Investment Balance	Interest earned	Approx. ROI	Budget	Difference	June 30, 2020	FY 2019-2020
Bank Accounts	$ 1,472,386	$ 15	0.00%			$ 711,039	633
State Treasurer Pool (LAIF) [1]	16,920,809	83,711	0.66%			13,308,410	186,619
Investment Advisor [1] [2]	125,293,791	1,819,949	1.94%			127,883,958	3,236,530
1986 Measure B Total	$ 143,686,986	$ 1,903,675	1.77%	$ 1,050,000	$ 853,675	$ 141,903,407	$ 3,423,782
						Approx. ROI	*2.41%*

2000 Measure B	Un-Audited	Interest Earned				FY 2019-2020	
		As of March 31, 2021				Investment Balance	Interest earned
	Investment Balance	Interest earned	Approx. ROI	Budget	Difference	June 30, 2020	FY 2019-2020
Bank Accounts	$ 7,395,215	$ 330	0.01%			$ 2,130,652	$ 16,495
State Treasurer Pool (LAIF) [1]	59,407,623	267,452	0.60%			48,329,778	628,781
Investment Advisor [1] [2]	121,565,622	1,749,072	1.92%			127,831,715	3,370,317
2014 Series A Bond Revenue Fund [1]	838	-	0.00%			838	10
2014 Series A Bond Interest Fund [1] [2]	424,976	427	0.07%			1,083,059	16,614
2014 Series A Bond Principal Fund [1] [2]	2,755,162	13,328	0.12%			8,708,557	212,053
Project Deferred Revenue [1] [3]	192,510	1,757	1.22%			402,273	9,764
2000 Measure B Total	$ 191,741,946	$ 2,032,366	1.41%	$ 1,218,750	$ 813,616	$ 188,486,872	$ 4,254,034
						Approx. ROI	*2.26%*

2014 Measure BB	Un-Audited	Interest Earned				FY 2019-2020	
		As of March 31, 2021				Investment Balance	Interest earned
	Investment Balance	Interest earned	Approx. ROI	Budget	Difference	June 30, 2020	FY 2019-2020
Bank Accounts	$ 12,426,315	$ 267	0.00%			$ 4,653,766	$ 15,538
State Treasurer Pool (LAIF) [1]	71,158,439	376,878	0.71%			60,913,897	1,212,667
Investment Advisor [1] [2]	62,508,151	279,026	0.60%			94,604,658	2,163,805
Project Deferred Revenue [1] [3]	1,571,765	4,029	0.34%			268,357	28,103
2014 Measure BB Total	$ 147,664,670	$ 660,200	0.60%	$ 491,250	$ 168,950	$ 160,440,678	$ 3,420,113
						Approx. ROI	*2.13%*

Non-Sales Tax	Un-Audited	Interest Earned				FY 2019-2020	
		As of March 31, 2021				Investment Balance	Interest earned
	Investment Balance	Interest earned	Approx. ROI	Budget	Difference	June 30, 2020	FY 2019-2020
Bank Accounts	$ 11,513,034	$ 559	0.01%			$ 3,934,443	$ 16,668
State Treasurer Pool (LAIF) [1]	48,018,687	218,003	0.61%			45,626,235	764,931
California Asset Management Program (CAMP)	57,659,403	81,401	0.19%			57,578,002	975,153
Project Deferred Revenue [1] [3]	12,443,476	54,171	0.58%			11,421,015	207,639
Non-Sales Tax Total	$ 129,634,600	$ 354,134	0.36%	$ 273,750	$ 80,384	$ 118,559,695	$ 1,964,391
						Approx. ROI	*1.66%*
Alameda CTC TOTAL	$ 612,728,202	$ 4,950,375	1.08%	$ 3,033,750	$ 1,916,625	$ 609,390,652	$ 13,062,320

Notes:

(1) All investments are marked to market on the financial statements at the end of the fiscal year per GASB 31 requirements.
(2) See attachments for detail of investment holdings managed by Investment Advisor.
(3) Project funds in deferred revenue are invested in LAIF with interest accruing back to the respective projects, as required per individual funding contracts.

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PUBLIC TRUST ADVISORS

Alameda County Transportation Commission
Portfolio Review for the Quarter Ending March 31, 2021

Fixed Income Market Review and Outlook

The U.S. economy continues to accelerate as the vaccination count advances and business restrictions ease. According to the Centers for Disease Control and Prevention, 32.6% of the U.S. population has received at least one dose of the COVID-19 vaccine, while 19% has been fully vaccinated. The swift rollout of vaccinations underpins the rise in consumer sentiment which registered a pandemic-high reading of 109.7 points in March as measured by the Conference Board Consumer Confidence Index. Federal stimulus distributions and increasing confidence in the recovery are expected to fuel a surge in household spending amongst a consumer base already flush with cash.

On the labor market front, nonfarm payrolls for the month of March shattered expectations as the 916,000 increase in employment came in well above the 660,000 survey estimate. The jobs report showed hiring rose across most industries, led by a 280,000 gain in the leisure and hospitality category. Despite growing improvement in the labor market, the Federal Reserve continues to maintain its dovish, or more accommodating, policies when assessing employment conditions. With the participation rate currently standing at just 61.5%, it would take approximately 5.2 million additional individuals reentering the labor force before returning to the pre-pandemic level. Reintroducing these workers as unemployed would translate to an unemployment rate close to 9.4% compared to March's reading of just 6.0%.

On March 31, the Biden administration unveiled its much anticipated $2.3 trillion infrastructure investment plan. The proposal encompasses roughly $620 billion related to transportation spending, $300 billion to bolster domestic manufacturing, $250 billion for research and development, $215 billion allocated to affordable housing, and the residual spending spread across community-based care and education. To fund this ambitious spending plan, President Biden is calling for $2 trillion in corporate tax increases over the next 15 years by proposing a raise in the corporate tax rate to 28% from the current rate of 21%.

The International Monetary Fund now projects the U.S. economy to expand by 6.4% this year which would mark the fastest annual pace of growth since 1984. Fed Chairman Powell, however, continues to reiterate that the Federal Reserve is in no hurry to change its easy monetary policy and that effects on inflation from stimulus distributions are expected to be transitory.

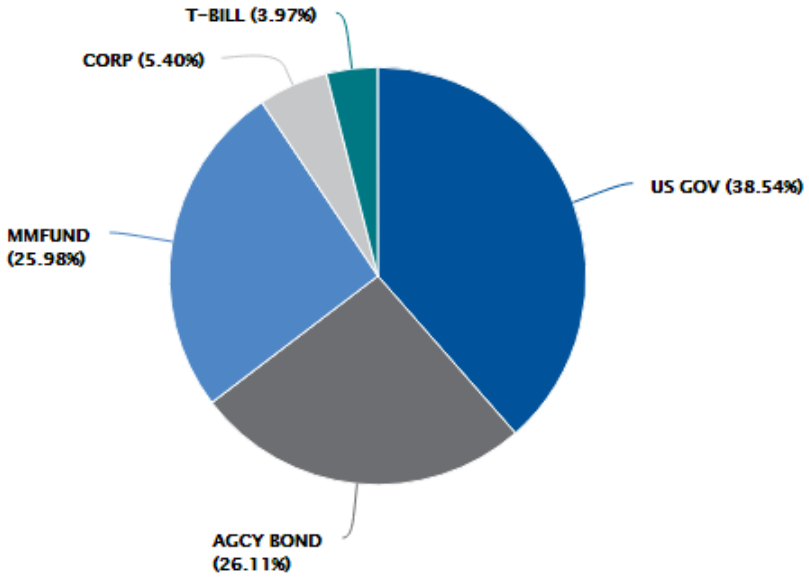
Short-term interest rates remain anchored by the Federal Reserve's near-zero interest rate policy and were generally unchanged over the quarter. By contrast, intermediate and long-term interest rates trended higher over the period as the combination of historically accommodative monetary and fiscal policies combined with the improving public health outlook and reopening optimism fueled a rise in inflation expectations. For the quarter, two-, five-, and ten-year U.S. Treasury yields rose 4 basis points (0.04%), 58 basis points (0.58%), and 83 basis points (0.83%), respectively. Amidst this backdrop and reflecting growing economic optimism and rising inflation expectatons, the yield spread between two- and ten-year Treasuries rose to 158 basis points (1.58%) from 79 basis points (0.79%) last quarter.

Investment Strategy Update

Alameda CTC's liquidity portfolios remain invested in short-term securities to match anticipated expenditure dates to provide necessary liquidity for ongoing project costs. The long-term core portfolios remain invested in eligible and permitted securities as set forth in Alameda CTC's investment policy and California state code. Over the quarter, the core portfolios' durations were modestly shorter than their benchmark which benefited portfolio performance as the yield curve steepened over the period. In addition, the portfolios' continued allocation to high-quality corporate bonds served to enhance overall portfolio yield and income.

Portfolio Allocation

Provided below is a summary of the Alameda CTC consolidated portfolio as of the quarter ended March 31, 2021.



U.S. Treasury Notes/Bonds:	38.54%
U.S. Agency Bonds:	26.11%
Money Market Fund:	25.98%
U.S. Corporate Bonds:	5.40%
U.S. Treasury Bills:	3.97%

Compliance with Investment Policy Statement

As of the quarter ending March 31, 2021, the Alameda CTC portfolios were in compliance with the adopted investment policy.

Core Portfolios

The performance for the core 1986 and 2000 Measure B portfolios (the Portfolios) is reported on a total return basis. This method includes the coupon interest, amortization of discounts and premiums, capital gains and losses and price changes (i.e., unrealized gains and losses), but does not include the deduction of management fees. Performance Portfolios for the quarter ending March 31, 2021 is summarized in the table below. The Portfolios outperformed their respective benchmarks over the quarter and benefited from their shorter duration profile as the yield curve steepened. In addition, the Portfolios' continued allocation to high-quality corporate bonds served to enhance overall core portfolio yield and income.

Core Portfolio & Benchmark Total Return [1]	
1986 Measure B Portfolio	**2000 Measure B Portfolio**
Portfolio Return: 0.02 %	Portfolio Return: -0.03 %
Benchmark Return: -0.04%	Benchmark Return: -0.04 %

[1] Note: Past performance is not an indication of future results. Performance is presented prior to the deduction of investment management fees.

1986 Measure B benchmark is the BofAML 1-3 Year AAA-AA US Corporate & Government Index.

2000 Measure B benchmark is the BofAML 1-3 Year AAA-AA US Corporate & Government Index.

Over the quarter, duration was generally shorter with values of 1.64 in the core 1986 Measure B portfolio and 1.65 in the core 2000 Measure B portfolio, compared to the benchmark duration of 1.83 as of March 31, 2021.

The Portfolios' yield to maturity, representing the return the Portfolios will earn in the future if all securities are held to maturity, is also reported below. This calculation is based on the current market value of the Portfolios including unrealized gains and losses. Portfolio yield to maturity for the quarter ending March 31, 2021 is summarized below:

Core Portfolio & Benchmark Yield to Maturity	
1986 Measure B Portfolio	**2000 Measure B Portfolio**
Portfolio YTM: 0.18%	Portfolio YTM: 0.18%
Benchmark YTM: 0.19%	Benchmark YTM: 0.19%

Liquidity and Bond Portfolios

The liquidity portions of the 1986 and 2000 Measure B portfolios (Liquidity portfolios), as well as the 2014 Measure BB and the Bond Interest and Principal Fund portfolios, remain invested in either short-term cash equivalents or permitted high-grade fixed income securities with maturity dates matched to appropriate anticipated expenditure and debt service payment dates.

One way to measure the anticipated return of the Liquidity and Bond portfolios is their yield to maturity. This is the return the portfolios will earn in the future if all securities are held to maturity. This calculation is based on the current market value of the portfolios. The yield to maturity and weighted average maturity (WAM) for the Liquidity and Bond portfolios and the comparable maturity of U.S. Treasury securities as of the quarter ending March 31, 2021 are summarized below:

Liquidity Portfolio & Comparable U.S. Treasury Security Yield to Maturity		
1986 Measure B Portfolio	**2000 Measure B Portfolio**	**2014 Measure BB Portfolio**
Portfolio YTM: 0.12%	Portfolio YTM: 0.08%	Portfolio YTM: 0.03%
Comparable TSY YTM: 0.07%	Comparable TSY YTM: 0.04%	Comparable TSY YTM: -0.02%
Portfolio WAM: 1.0 Years	Portfolio WAM: 0.5 Years	Portfolio WAM: 0.0 Years

Note: WAM is the weighted average amount of time until the securities in the portfolio mature.

Bond Portfolio & Comparable U.S. Treasury Security Yield to Maturity	
Interest Fund Portfolio	**Principal Fund Portfolio**
Portfolio YTM: 0.03%	Portfolio YTM: 0.09%
Comparable TSY YTM: -0.02%	Comparable TSY YTM: 0.07%
Portfolio WAM: 0.0 Years	Portfolio WAM: 0.87 Years

Note: WAM is the weighted average amount of time until the securities in the portfolio mature.

For the quarter ending March 31, 2021, the Alameda CTC Series 2014 Bonds Interest Fund and Principal Fund portfolios were invested in compliance with Section 5.11 of the Bond Indenture dated February 1, 2014.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC 1986 Measure B (159781)

Dated: 04/15/2021

AGCY BOND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G04Q3	05/22/2023	2,480,000.00	100.1216	2,483,016.10	2,474,544.00	2,476,036.15	0.325	1.955%	AA+	Aaa
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G05G4	07/10/2023	1,850,000.00	100.0719	1,851,330.24	1,849,790.95	1,849,832.36	0.254	1.458%	AA+	Aaa
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G0S38	01/05/2022	5,800,000.00	101.4361	5,883,293.28	5,705,283.80	5,775,621.94	2.575	4.632%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAER6	05/05/2023	2,500,000.00	100.4257	2,510,643.75	2,503,150.00	2,502,230.40	0.332	1.977%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAES4	06/26/2023	1,850,000.00	100.0789	1,851,459.26	1,850,111.00	1,850,088.71	0.248	1.458%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAEV7	08/24/2023	1,850,000.00	100.0296	1,850,547.64	1,850,162.80	1,850,131.90	0.247	1.457%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AFE78	12/09/2022	5,300,000.00	104.7465	5,551,562.86	5,367,787.00	5,329,412.50	2.651	4.371%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130ADRG9	03/10/2023	4,600,000.00	104.9084	4,825,786.77	4,613,018.00	4,606,091.70	2.677	3.800%	AA+	Aaa
FEDERAL HOME LOAN BANKS	313381BR5	12/09/2022	2,285,000.00	102.8642	2,350,446.15	2,313,242.60	2,301,691.27	1.432	1.851%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3133834G3	06/09/2023	2,480,000.00	104.2063	2,584,315.87	2,612,010.40	2,576,501.66	0.337	2.035%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AKDH6	10/21/2022	1,720,000.00	99.9357	1,718,894.64	1,717,729.60	1,718,231.02	0.191	1.353%	AA+	Aaa
FEDERAL HOME LOAN BANKS	313376C94	12/10/2021	2,285,000.00	101.7657	2,325,346.40	2,333,053.55	2,302,878.75	1.475	1.831%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AFFN2	12/10/2021	3,300,000.00	102.0176	3,366,581.49	3,335,475.00	3,308,483.15	2.611	2.651%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133ELGN8	10/13/2022	2,285,000.00	102.2232	2,335,800.30	2,294,962.60	2,290,652.54	1.435	1.839%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133ELWD2	04/08/2022	2,500,000.00	100.2756	2,506,890.05	2,505,500.00	2,502,978.17	0.258	1.974%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133EMGX4	11/23/2022	1,450,000.00	99.9908	1,449,867.32	1,447,941.00	1,448,304.85	0.196	1.142%	AA+	Aaa
---	**---**	**10/26/2022**	**44,535,000.00**	**102.0816**	**45,445,782.13**	**44,773,762.30**	**44,689,167.06**	**1.459**	**35.784%**	**AA+**	**Aaa**

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	138.87	1.0000	138.87	138.87	138.87	0.000	0.000%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**138.87**	**1.0000**	**138.87**	**138.87**	**138.87**	**0.000**	**0.000%**	**AA+**	**Aaa**

CORP

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
TOYOTA MOTOR CREDIT CORP	89233P5T9	01/12/2022	1,300,000.00	102.2668	1,329,467.93	1,316,588.00	1,304,518.26	2.834	1.047%	A+	A1
PFIZER INC	717081DZ3	12/15/2021	1,300,000.00	101.3265	1,317,244.64	1,301,768.00	1,300,496.89	2.144	1.037%	A+	A2
PEPSICO INC	713448BW7	08/25/2021	1,300,000.00	101.0824	1,314,071.47	1,323,959.00	1,304,339.97	2.139	1.035%	A+	A1
ORACLE CORP	68389XBA2	07/08/2021	1,300,000.00	100.6575	1,308,547.12	1,300,949.00	1,300,107.89	2.767	1.030%	A	Baa2
MICROSOFT CORP	594918BH6	11/03/2022	1,000,000.00	103.5282	1,035,282.02	1,023,660.00	1,012,802.50	1.726	0.815%	AAA	Aaa
BERKSHIRE HATHAWAY INC	084670BC1	08/15/2021	1,125,000.00	101.3089	1,139,724.66	1,154,621.25	1,139,975.80	0.182	0.897%	AA	Aa2
APPLE INC	037833DC1	09/12/2022	2,000,000.00	102.5926	2,051,851.54	2,028,106.00	2,015,347.36	1.525	1.616%	AA+	Aa1
---	**---**	**01/29/2022**	**9,325,000.00**	**101.8441**	**9,496,189.39**	**9,449,651.25**	**9,377,588.65**	**1.910**	**7.477%**	**AA-**	**A1**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	6,094,235.53	1.0000	6,094,235.53	6,094,235.53	6,094,235.53	0.030	4.799%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**6,094,235.53**	**1.0000**	**6,094,235.53**	**6,094,235.53**	**6,094,235.53**	**0.030**	**4.799%**	**AAAm**	**Aaa**

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC 1986 Measure B (159781)

Dated: 04/15/2021

T-BILL

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	912796D97	04/20/2021	2,325,000.00	99.9989	2,324,974.42	2,324,030.28	2,324,880.36	0.099	1.831%	A-1+	P-1
UNITED STATES TREASURY	**912796D97**	**04/20/2021**	**2,325,000.00**	**99.9989**	**2,324,974.42**	**2,324,030.28**	**2,324,880.36**	**0.099**	**1.831%**	**A-1+**	**P-1**

US GOV

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	912828XW5	06/30/2022	5,700,000.00	102.0352	5,816,006.40	5,557,500.00	5,648,541.66	2.510	4.579%	AA+	Aaa
UNITED STATES TREASURY	912828L57	09/30/2022	5,300,000.00	102.4180	5,428,154.00	5,156,734.38	5,242,036.77	2.519	4.274%	AA+	Aaa
UNITED STATES TREASURY	912828XD7	05/31/2022	1,725,000.00	102.0586	1,760,510.85	1,727,425.78	1,725,949.32	1.826	1.386%	AA+	Aaa
UNITED STATES TREASURY	9128286Y1	06/15/2022	2,200,000.00	101.9766	2,243,485.20	2,197,765.61	2,199,081.19	1.786	1.767%	AA+	Aaa
UNITED STATES TREASURY	912828XW5	06/30/2022	2,200,000.00	102.0352	2,244,774.40	2,196,992.18	2,198,738.66	1.797	1.768%	AA+	Aaa
UNITED STATES TREASURY	9128287C8	07/15/2022	2,100,000.00	102.1055	2,144,215.50	2,105,906.25	2,102,713.53	1.647	1.688%	AA+	Aaa
UNITED STATES TREASURY	9128282S8	08/31/2022	2,100,000.00	102.1133	2,144,379.30	2,099,015.63	2,099,524.37	1.641	1.688%	AA+	Aaa
UNITED STATES TREASURY	912828YK0	10/15/2022	2,600,000.00	101.8984	2,649,358.40	2,581,414.06	2,589,888.38	1.634	2.086%	AA+	Aaa
UNITED STATES TREASURY	912828TY6	11/15/2022	2,600,000.00	102.3984	2,662,358.40	2,599,492.19	2,599,716.98	1.632	2.096%	AA+	Aaa
UNITED STATES TREASURY	9128284P2	05/15/2021	4,000,000.00	100.3104	4,012,416.00	3,997,031.24	3,999,879.16	2.651	3.159%	AA+	Aaa
UNITED STATES TREASURY	912828ZD5	03/15/2023	1,840,000.00	100.6445	1,851,858.80	1,854,878.13	1,850,319.17	0.212	1.458%	AA+	Aaa
UNITED STATES TREASURY	912828Z86	02/15/2023	1,840,000.00	102.2734	1,881,830.56	1,898,937.50	1,880,372.19	0.201	1.482%	AA+	Aaa
UNITED STATES TREASURY	912828Z29	01/15/2023	1,840,000.00	102.3984	1,884,130.56	1,903,034.37	1,882,543.32	0.204	1.484%	AA+	Aaa
UNITED STATES TREASURY	912828ZH6	04/15/2023	1,850,000.00	100.1406	1,852,601.10	1,854,769.53	1,853,739.23	0.151	1.459%	AA+	Aaa
UNITED STATES TREASURY	9128285A4	09/15/2021	3,900,000.00	101.2148	3,947,377.20	3,923,765.63	3,904,083.19	2.511	3.108%	AA+	Aaa
UNITED STATES TREASURY	912828F96	10/31/2021	1,150,000.00	101.1289	1,162,982.35	1,170,484.38	1,162,537.85	0.129	0.916%	AA+	Aaa
UNITED STATES TREASURY	9128283C2	10/31/2022	1,450,000.00	102.9336	1,492,537.20	1,501,429.69	1,491,691.95	0.180	1.175%	AA+	Aaa
UNITED STATES TREASURY	9128286C9	02/15/2022	1,400,000.00	102.1133	1,429,586.20	1,408,203.13	1,402,500.00	2.288	1.126%	AA+	Aaa
UNITED STATES TREASURY	91282CAP6	10/15/2023	2,750,000.00	99.6602	2,740,655.50	2,740,654.29	2,740,984.94	0.255	2.158%	AA+	Aaa
UNITED STATES TREASURY	91282CAW1	11/15/2023	2,750,000.00	99.9375	2,748,281.25	2,748,388.67	2,748,443.90	0.272	2.164%	AA+	Aaa
UNITED STATES TREASURY	91282CBA8	12/15/2023	2,750,000.00	99.5430	2,737,432.50	2,737,646.48	2,738,057.46	0.286	2.155%	AA+	Aaa
UNITED STATES TREASURY	912828J43	02/28/2022	2,000,000.00	101.5156	2,030,312.00	2,005,390.62	2,002,232.68	1.625	1.599%	AA+	Aaa
UNITED STATES TREASURY	91282CAK7	09/15/2023	2,750,000.00	99.7148	2,742,157.00	2,741,943.35	2,742,237.58	0.240	2.159%	AA+	Aaa
UNITED STATES TREASURY	91282CAR2	10/31/2022	2,000,000.00	99.9883	1,999,766.00	1,999,453.12	1,999,483.50	0.141	1.575%	AA+	Aaa
UNITED STATES TREASURY	912828J76	03/31/2022	2,000,000.00	101.6562	2,033,124.00	2,006,015.62	2,002,622.38	1.615	1.601%	AA+	Aaa
UNITED STATES TREASURY	**---**	**09/18/2022**	**62,795,000.00**	**101.3574**	**63,640,290.67**	**62,714,271.83**	**62,807,919.36**	**1.417**	**50.110%**	**AA+**	**Aaa**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**08/10/2022**	**125,074,374.40**	**96.8291**	**127,001,611.02**	**125,356,090.07**	**125,293,929.83**	**1.377**	**100.000%**	**AA+**	**Aa1**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC 2000 Measure B (159783)

Dated: 04/15/2021

AGCY BOND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G04Q3	05/22/2023	1,370,000.00	100.1216	1,371,666.15	1,366,986.00	1,367,810.29	0.325	1.119%	AA+	Aaa
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G05G4	07/10/2023	1,425,000.00	100.0719	1,426,024.65	1,424,838.98	1,424,870.87	0.254	1.163%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAER6	05/05/2023	2,300,000.00	100.4257	2,309,792.25	2,302,898.00	2,302,051.97	0.332	1.884%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAES4	06/26/2023	1,425,000.00	100.0789	1,426,124.03	1,425,085.50	1,425,068.33	0.248	1.163%	AA+	Aaa
FEDERAL HOME LOAN MORTGAGE CORP	3137EAEV7	08/24/2023	1,425,000.00	100.0296	1,425,421.83	1,425,125.40	1,425,101.60	0.247	1.163%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AFE78	12/09/2022	3,500,000.00	104.7465	3,666,126.42	3,544,765.00	3,519,423.35	2.651	2.991%	AA+	Aaa
FEDERAL HOME LOAN BANKS	313381BR5	12/09/2022	2,200,000.00	102.8642	2,263,011.61	2,227,192.00	2,216,070.37	1.432	1.846%	AA+	Aaa
FEDERAL HOME LOAN BANKS	313379Q69	06/10/2022	2,225,000.00	102.3775	2,277,900.47	2,310,818.25	2,274,774.58	0.240	1.858%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3133834G3	06/09/2023	1,370,000.00	104.2063	1,427,626.10	1,442,925.10	1,423,309.38	0.337	1.165%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AKDH6	10/21/2022	2,205,000.00	99.9357	2,203,582.96	2,202,089.40	2,202,732.21	0.191	1.798%	AA+	Aaa
FEDERAL HOME LOAN BANKS	3130AFFN2	12/10/2021	6,500,000.00	102.0176	6,631,145.37	6,569,875.00	6,516,709.24	2.611	5.410%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133ELGN8	10/13/2022	2,200,000.00	102.2232	2,248,910.58	2,209,592.00	2,205,442.27	1.435	1.835%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133ELWD2	04/08/2022	2,300,000.00	100.2756	2,306,338.85	2,305,060.00	2,302,739.91	0.258	1.882%	AA+	Aaa
FEDERAL FARM CREDIT BANKS FUNDING CORP	3133EMGX4	11/23/2022	2,045,000.00	99.9908	2,044,812.88	2,042,096.10	2,042,609.25	0.196	1.668%	AA+	Aaa
---	**---**	**10/13/2022**	**32,490,000.00**	**101.6871**	**33,028,484.12**	**32,799,346.73**	**32,648,713.63**	**1.149**	**26.946%**	**AA+**	**Aaa**

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	352.40	1.0000	352.40	352.40	352.40	0.000	0.000%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**352.40**	**1.0000**	**352.40**	**352.40**	**352.40**	**0.000**	**0.000%**	**AA+**	**Aaa**

CORP

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
TOYOTA MOTOR CREDIT CORP	89233P5T9	01/12/2022	1,350,000.00	102.2668	1,380,601.31	1,367,226.00	1,354,692.03	2.834	1.126%	A+	A1
ORACLE CORP	68389XBA2	07/08/2021	1,350,000.00	100.6575	1,358,875.86	1,350,985.50	1,350,112.04	2.767	1.109%	A	Baa2
MICROSOFT CORP	594918BH6	11/03/2022	1,675,000.00	103.5282	1,734,097.38	1,714,630.50	1,696,444.18	1.726	1.415%	AAA	Aaa
BERKSHIRE HATHAWAY INC	084670BC1	08/15/2021	1,500,000.00	101.3089	1,519,632.89	1,539,495.00	1,519,967.73	0.182	1.240%	AA	Aa2
APPLE INC	037833CM0	02/09/2022	1,350,000.00	101.7488	1,373,608.88	1,341,454.50	1,347,494.60	2.726	1.121%	AA+	Aa1
---	**---**	**01/21/2022**	**7,225,000.00**	**101.9746**	**7,366,816.32**	**7,313,791.50**	**7,268,710.59**	**1.989**	**6.010%**	**AA-**	**A1**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	22,463,024.33	1.0000	22,463,024.33	22,463,024.33	22,463,024.33	0.030	18.326%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**22,463,024.33**	**1.0000**	**22,463,024.33**	**22,463,024.33**	**22,463,024.33**	**0.030**	**18.326%**	**AAAm**	**Aaa**

T-BILL

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	912796D97	04/20/2021	3,075,000.00	99.9989	3,074,966.17	3,073,717.47	3,074,841.77	0.099	2.509%	A-1+	P-1
UNITED STATES TREASURY	**912796D97**	**04/20/2021**	**3,075,000.00**	**99.9989**	**3,074,966.17**	**3,073,717.47**	**3,074,841.77**	**0.099**	**2.509%**	**A-1+**	**P-1**

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC 2000 Measure B (159783)

Dated: 04/15/2021

US GOV

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	912828XW5	06/30/2022	4,000,000.00	102.0352	4,081,408.00	3,900,000.00	3,963,888.89	2.510	3.330%	AA+	Aaa
UNITED STATES TREASURY	912828S35	06/30/2023	500,000.00	102.6211	513,105.50	476,250.00	487,873.60	2.522	0.419%	AA+	Aaa
UNITED STATES TREASURY	9128286Y1	06/15/2022	1,950,000.00	101.9766	1,988,543.70	1,948,019.52	1,949,185.60	1.786	1.622%	AA+	Aaa
UNITED STATES TREASURY	912828XW5	06/30/2022	1,950,000.00	102.0352	1,989,686.40	1,947,333.98	1,948,881.99	1.797	1.623%	AA+	Aaa
UNITED STATES TREASURY	9128282S8	08/31/2022	2,000,000.00	102.1133	2,042,266.00	2,000,234.38	2,000,122.65	1.620	1.666%	AA+	Aaa
UNITED STATES TREASURY	912828XD7	05/31/2022	1,900,000.00	102.0586	1,939,113.40	1,911,949.22	1,905,667.88	1.612	1.582%	AA+	Aaa
UNITED STATES TREASURY	912828WZ9	04/30/2022	1,900,000.00	101.7695	1,933,620.50	1,905,789.06	1,902,636.87	1.618	1.578%	AA+	Aaa
UNITED STATES TREASURY	912828YF1	09/15/2022	2,000,000.00	101.9883	2,039,766.00	1,993,906.25	1,996,767.82	1.614	1.664%	AA+	Aaa
UNITED STATES TREASURY	912828TY6	11/15/2022	2,000,000.00	102.3984	2,047,968.00	1,999,609.38	1,999,782.30	1.632	1.671%	AA+	Aaa
UNITED STATES TREASURY	912828YK0	10/15/2022	2,000,000.00	101.8984	2,037,968.00	1,985,703.12	1,992,221.83	1.634	1.663%	AA+	Aaa
UNITED STATES TREASURY	912828Z29	01/15/2023	1,900,000.00	102.3984	1,945,569.60	1,965,089.84	1,943,930.60	0.204	1.587%	AA+	Aaa
UNITED STATES TREASURY	912828ZD5	03/15/2023	1,900,000.00	100.6445	1,912,245.50	1,915,363.29	1,910,655.67	0.212	1.560%	AA+	Aaa
UNITED STATES TREASURY	912828Z86	02/15/2023	1,900,000.00	102.2734	1,943,194.60	1,960,859.38	1,941,688.68	0.201	1.585%	AA+	Aaa
UNITED STATES TREASURY	912828WR7	06/30/2021	7,500,000.00	100.5107	7,538,302.50	7,430,566.43	7,493,017.85	2.516	6.150%	AA+	Aaa
UNITED STATES TREASURY	912828WR7	06/30/2021	2,300,000.00	100.5107	2,311,746.10	2,284,457.04	2,298,320.69	2.431	1.886%	AA+	Aaa
UNITED STATES TREASURY	912828ZH6	04/15/2023	1,425,000.00	100.1406	1,427,003.55	1,428,673.83	1,427,880.22	0.151	1.164%	AA+	Aaa
UNITED STATES TREASURY	9128283C2	10/31/2022	1,875,000.00	102.9336	1,930,005.00	1,941,503.91	1,928,912.01	0.180	1.575%	AA+	Aaa
UNITED STATES TREASURY	912828F96	10/31/2021	1,500,000.00	101.1289	1,516,933.50	1,526,718.75	1,516,353.72	0.129	1.238%	AA+	Aaa
UNITED STATES TREASURY	91282CAW1	11/15/2023	2,550,000.00	99.9375	2,548,406.25	2,556,873.04	2,556,448.94	0.153	2.079%	AA+	Aaa
UNITED STATES TREASURY	91282CBA8	12/15/2023	2,550,000.00	99.5430	2,538,346.50	2,547,011.73	2,547,190.86	0.166	2.071%	AA+	Aaa
UNITED STATES TREASURY	91282CAP6	10/15/2023	2,550,000.00	99.6602	2,541,335.10	2,548,007.81	2,548,134.59	0.154	2.073%	AA+	Aaa
UNITED STATES TREASURY	91282CAK7	09/15/2023	2,550,000.00	99.7148	2,542,727.40	2,548,107.42	2,548,231.62	0.153	2.074%	AA+	Aaa
UNITED STATES TREASURY	91282CAR2	10/31/2022	1,850,000.00	99.9883	1,849,783.55	1,850,361.32	1,850,325.81	0.114	1.509%	AA+	Aaa
UNITED STATES TREASURY	912828ZP8	05/15/2023	1,550,000.00	99.8633	1,547,881.15	1,549,697.27	1,549,720.06	0.134	1.263%	AA+	Aaa
UNITED STATES TREASURY	912828J76	03/31/2022	1,900,000.00	101.6562	1,931,467.80	1,905,714.84	1,902,491.26	1.615	1.576%	AA+	Aaa
UNITED STATES TREASURY	**---**	**09/13/2022**	**56,000,000.00**	**101.1521**	**56,638,393.60**	**56,027,800.81**	**56,110,331.97**	**1.227**	**46.208%**	**AA+**	**Aaa**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**05/20/2022**	**121,253,376.73**	**83.0223**	**122,572,036.95**	**121,678,033.23**	**121,565,974.69**	**1.003**	**100.000%**	**AA+**	**Aa1**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC 2014 Measure BB (159782)

Dated: 04/15/2021

AGCY BOND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
FEDERAL NATIONAL MORTGAGE ASSOCIATION	3135G0U27	04/13/2021	3,000,000.00	100.0819	3,002,457.42	3,028,710.00	3,002,376.00	0.106	4.803%	AA+	Aaa
FEDERAL NATIONAL MORTGAGE ASSOCIATION	**3135G0U27**	**04/13/2021**	**3,000,000.00**	**100.0819**	**3,002,457.42**	**3,028,710.00**	**3,002,376.00**	**0.106**	**4.803%**	**AA+**	**Aaa**

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	1,114.42	1.0000	1,114.42	1,114.42	1,114.42	0.000	0.002%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**1,114.42**	**1.0000**	**1,114.42**	**1,114.42**	**1,114.42**	**0.000**	**0.002%**	**AA+**	**Aaa**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	52,506,086.93	1.0000	52,506,086.93	52,506,086.93	52,506,086.93	0.030	83.997%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**52,506,086.93**	**1.0000**	**52,506,086.93**	**52,506,086.93**	**52,506,086.93**	**0.030**	**83.997%**	**AAAm**	**Aaa**

T-BILL

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	912796D97	04/20/2021	2,500,000.00	99.9989	2,499,972.50	2,499,082.72	2,499,885.34	0.088	3.999%	A-1+	P-1
UNITED STATES TREASURY	912796D89	04/13/2021	2,500,000.00	99.9998	2,499,995.00	2,499,134.03	2,499,928.33	0.087	3.999%	A-1+	P-1
UNITED STATES TREASURY	912796F20	04/27/2021	2,000,000.00	99.9987	1,999,974.00	1,999,255.68	1,999,874.34	0.088	3.199%	A-1+	P-1
UNITED STATES TREASURY	**---**	**04/19/2021**	**7,000,000.00**	**99.9992**	**6,999,941.50**	**6,997,472.43**	**6,999,688.01**	**0.088**	**11.198%**	**A-1+**	**P-1**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**04/03/2021**	**62,507,201.35**	**16.8918**	**62,509,600.27**	**62,533,383.78**	**62,509,265.36**	**0.040**	**100.000%**	**AAA**	**Aaa**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC Series 2014-Interest Fd (159784)

Dated: 04/15/2021

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	10.06	1.0000	10.06	10.06	10.06	0.000	0.002%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**10.06**	**1.0000**	**10.06**	**10.06**	**10.06**	**0.000**	**0.002%**	**AA+**	**Aaa**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	424,975.70	1.0000	424,975.70	424,975.70	424,975.70	0.030	99.998%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**424,975.70**	**1.0000**	**424,975.70**	**424,975.70**	**424,975.70**	**0.030**	**99.998%**	**AAAm**	**Aaa**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**03/31/2021**	**424,985.76**	**1.0000**	**424,985.76**	**424,985.76**	**424,985.76**	**0.030**	**100.000%**	**AAA**	**Aaa**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC Series 2014-Principal Fd (159786)

Dated: 04/15/2021

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	55.84	1.0000	55.84	55.84	55.84	0.000	0.002%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**55.84**	**1.0000**	**55.84**	**55.84**	**55.84**	**0.000**	**0.002%**	**AA+**	**Aaa**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	23,121.28	1.0000	23,121.28	23,121.28	23,121.28	0.030	0.839%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**23,121.28**	**1.0000**	**23,121.28**	**23,121.28**	**23,121.28**	**0.030**	**0.839%**	**AAAm**	**Aaa**

US GOV

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
UNITED STATES TREASURY	9128286C9	02/15/2022	2,675,000.00	102.1133	2,731,530.77	2,732,575.20	2,732,040.45	0.064	99.159%	AA+	Aaa
UNITED STATES TREASURY	**9128286C9**	**02/15/2022**	**2,675,000.00**	**102.1133**	**2,731,530.77**	**2,732,575.20**	**2,732,040.45**	**0.064**	**99.159%**	**AA+**	**Aaa**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**02/12/2022**	**2,698,177.12**	**101.2651**	**2,754,707.89**	**2,755,752.32**	**2,755,217.57**	**0.064**	**100.000%**	**AA+**	**Aaa**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

Holdings by Security Type ACTC

Base Currency: USD As of 03/31/2021

ACTC Series 2014-Revenue Fd (159787)

Dated: 04/15/2021

CASH

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
Receivable	CCYUSD	03/31/2021	0.02	1.0000	0.02	0.02	0.02	0.000	0.002%	AA+	Aaa
Receivable	**CCYUSD**	**03/31/2021**	**0.02**	**1.0000**	**0.02**	**0.02**	**0.02**	**0.000**	**0.002%**	**AA+**	**Aaa**

MMFUND

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
MORG STAN I LQ:GV I	61747C707	03/31/2021	838.31	1.0000	838.31	838.31	838.31	0.030	99.998%	AAAm	Aaa
MORG STAN I LQ:GV I	**61747C707**	**03/31/2021**	**838.31**	**1.0000**	**838.31**	**838.31**	**838.31**	**0.030**	**99.998%**	**AAAm**	**Aaa**

Summary

Description	Identifier	Final Maturity	Current Units	Market Price	Market Value	Original Cost	Book Value	Book Yield	% of Market Value	S&P Rating	Moody's Rating
---	**---**	**03/31/2021**	**838.33**	**1.0000**	**838.33**	**838.33**	**838.33**	**0.030**	**100.000%**	**AAA**	**Aaa**

* Grouped by: Security Type. * Groups Sorted by: Security Type. * Weighted by: Market Value + Accrued, except Book Yield by Base Book Value + Accrued. * Holdings Displayed by: Lot.

DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Administration Lily Balinton, Principal Financial Analyst
SUBJECT:	Approve an Update to the Alameda CTC Investment Policy

Recommendation

It is recommended that the Commission approve an update to the Alameda CTC investment policy that was adopted in May 2020.

Summary

An update to the Alameda CTC investment policy is attached as a red line version to show recommended changes since the investment policy was adopted in May 2020. The recommended changes to the policy include administrative edits to clarify ambiguous language and incorporate state statutory updates effective January 1, 2021 under Senate Bill (SB) 998 which updates, clarifies, and strengthens the California Government Code (the Code) with amendments to Sections 53601(h), 53601(k), and 53601.6. Under SB 998, and since Alameda CTC has more than $100 million of investments, the agency is authorized to augment the investment policy to include the following changes:

- Increase the allowable limit for investments in commercial paper from 25% to 40% (per the Code Section 53601(h));
- Prohibit the investment of more than 10% of total investment assets in the commercial paper and medium-term notes of any single issuer (per the Code Sections 53601(h) and 53601(k)); and
- Allow for the investment in securities issued by, or backed by, the United States Government that could result in zero or negative interest accrual if held to maturity, in the event of, and for the duration of, a period of negative market interest rates (per the Code Section 53601.6(b)(2)).

Due to the sunset provision, on and after January 1, 2026, unless a subsequent bill amends Sections 53601 and 53601.6 of the Code, the provisions authorizing certain local agencies with investable assets in excess of $100 million to invest 40% of their moneys in eligible

commercial paper will expire reverting back to a limit of 25% and all local agencies will again be prohibited from investing funds in securities that could result in zero interest accrual if held to maturity even during a period of negative market interest rates. However, the 10% single issuer limitation for commercial paper and medium-term notes will remain in effect. Staff will continue to bring the investment policy to the Commission for review annually, as is best practice, and monitor changes to the Code. If there is a rescission of these changes to the Code on January 1, 2026, Alameda CTC's investment policy will be updated at that time.

Background

The California Government Code (the Code) Section 53600.5 states, "… the primary objective of a trustee shall be to safeguard the principal of the funds under its control. The secondary objective shall be to meet the liquidity needs of the depositor. The third objective shall be to achieve a return on the funds under its control." These objectives also are reflected in Alameda CTC's investment policy, in the order of priority demonstrated in the Code. Staff has reviewed the investment policy in consultation with investment advisors and is recommending changes to the currently adopted investment policy to incorporate the recent state statutory updates that became effective January 1, 2021 under Senate Bill 998 and to make administrative edits to remove ambiguity in the policy. The current investment policy was adopted by the Commission in May 2020.

The attached investment policy (Attachment A) was developed in accordance with the Code in order to define parameters and guide staff and investment advisors in managing Alameda CTC's investment portfolio. The policy formalizes the framework for Alameda CTC's investment activities that must be exercised to ensure effective and prudent fiscal management of Alameda CTC's funds. The guidelines are intended to be broad enough to allow staff and the investment advisors to function properly within the parameters of fiscal responsibility and authority, yet specific enough to adequately safeguard the investment assets.

The primary objectives of the investment activities within the policy safeguard Alameda CTC assets by mitigating credit and interest rate risk, provide adequate liquidity to meet all operating requirements of Alameda CTC, and attain a market rate of return on investments taking into account the investment risk constraints of safety and liquidity needs.

Through the proposed investment policy, the Commission appoints the Executive Director and the Deputy Executive Director of Finance and Administration as Investment Officers who are responsible for the investment program of the Alameda CTC and will act responsibly as custodians of the public trust. The policy requires the Investment Officers to design internal controls around investments that would prevent the loss of public funds from fraud, employee error, misrepresentation by third parties, unanticipated changes in financial markets or imprudent actions by employees and officers of Alameda CTC. It also allows the Investment Officers to periodically reset performance benchmarks to reflect changing investment objectives and constraints.

Fiscal Impact: There is no fiscal impact to the approval of this investment policy.

Attachment:

A. Draft Alameda CTC Investment Policy May 2021

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Alameda County Transportation Commission
Investment Policy
May 2021~~0~~

I. Introduction
The intent of the Investment Policy of the Alameda County Transportation Commission (Alameda CTC) is to define the parameters within which funds are to be managed. The policy formalizes the framework for Alameda CTC's investment activities that must be exercised to ensure effective and prudent fiscal and investment management of Alameda CTC's funds. The guidelines are intended to be broad enough to allow Alameda CTC's Investment Officers (as defined below) to function properly within the parameters of responsibility and authority, yet specific enough to adequately safeguard the investment assets.

II. Governing Authority
The investment program shall be operated in conformance with federal, state, and other legal requirements, including the California Government Code.

III. Scope
This policy applies to activities of Alameda CTC with regard to investing the financial assets of all funds (except bond funds and retirement funds). In addition, any funds held by trustees or fiscal agents are excluded from these rules; however, all such funds are subject to regulations established by the State of California.

Note that any excluded funds such as employee retirement funds, proceeds from certain bond issuances and Other Postemployment Benefits (OPEB) trust assets are covered by separate policies.

IV. General Objectives
The primary objectives, in order of priority, of investment activities shall be:

1. *Safety*

Safety of principal is the foremost objective of the investment program. Investments shall be undertaken in a manner that seeks to ensure the preservation of capital in the overall portfolio. The goal will be to mitigate credit and interest rate risk.

2. *Liquidity*

The investment portfolio shall remain sufficiently liquid to meet all operating requirements that may be reasonably anticipated.

3. *Return*

The investment portfolio shall be designed with the objective of attaining a market rate of return throughout budgetary and economic cycles, taking into account the investment risk contraints of safety and liquidity needs.

V. Standard of Care

1. *Prudence*

The standard of prudence to be used by investment officials shall be the "prudent investor" standard (California Government Code Section 53600.3) and shall be applied in the context of managing an overall portfolio. Investment Officers acting in accordance with written procedures and the investment policy and exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control adverse developments.

> "When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency. Within the limitations of this section and considering individual investments as part of an overall strategy, investments may be acquired as authorized by law."

2. Delegation of Authority and Responsibilities

Responsibilities of the Commission - The Commission, in its role as Alameda CTC's governing body, will retain ultimate fiduciary responsibility for the portfolios. They will receive quarterly reports for review, designate Investment Officers and annually review and adopt the investment policy.

The Commission hereby designates the Executive Director and the Deputy Executive Director of Finance and Administration, as Treasurer, as the Investment Officers.

Responsibilities of the Investment Officers - The Investment Officers are jointly responsible for the operation of the investment program. The Investment Officers shall act in accordance with written procedures and internal controls for the operation of the investment program consistent with the Investment Policy. All participants in the investment process shall seek to act responsibly as custodians of the public trust. No officer may engage in an investment transaction except as provided under the terms of this policy and supporting procedures.

Responsibilities of the Investment Advisor - Alameda CTC may engage the services of one or more external investment advisors to assist in the management of the investment portfolio in a manner consistent with Alameda CTC's objectives. Investment advisors may be granted discretion to purchase and sell investment securities in accordance with this Investment Policy and the California Government Code and must be registered under the Investment Advisors Act of 1940 or be a bank, regulated by the Office of the Comptroller of the Currency (OCC) or Federal Reserve operating under the fiduciary exemption from the Security and Exchange Commission. Any investment advisor shall be required to prepare and provide comprehensive reports on Alameda CTC's investments on a monthly and quarterly basis, and as requested by Alameda CTC's Investment Officers. At no time shall the investment advisor maintain custody of Alameda CTC cash or assets.

Responsibilities of the Custodian - A third party bank custodian shall hold Alameda CTC cash and assets under management by any investment advisor in the name of Alameda CTC. The custodian shall receive direction from the investment advisor on settlement of investment transactions.

VI. Selection of Financial Institutions and Broker/Dealers

Alameda CTC's procedures are designed to encourage competitive bidding on transactions from an approved list of broker/dealers in order to provide for the best execution on transactions.

The Investment Officer, or the investment advisors, shall maintain a list of authorized broker/dealers and financial institutions that are approved for investment purposes. This list will be developed after a process of due diligence confirming that the firms qualify under the Securities and Exchange Commission Rule 15C3-1 (uniform net capital rule). Alameda CTC shall purchase securities only from authorized institutions or firms.

The Investment Officer, or the investment advisor, shall obtain competitive offers on all purchases of investment instruments purchased on the secondary market whenever possible. A competitive bid can be executed through a bidding process involving at least three separate brokers/financial institutions or through the use of a nationally recognized trading platform.

VII. Safekeeping and Custody

1. *Delivery vs. Payment*

All trades of marketable securities will be executed on a delivery vs. payment (DVP) basis to ensure that securities are deposited in Alameda CTC's safekeeping institution prior to the release of funds.

2. *Third-Party Safekeeping*

Securities will be held by an independent third-party safekeeping institution selected by Alameda CTC's Investment Officers. All securities will be evidenced by safekeeping receipts in Alameda CTC's name. The safekeeping institution shall annually provide a copy of its most recent report on internal controls – Service Organization Control Reports (formerly SAS 70) prepared in accordance with the Statement on Standards for Attestation Engagements (SSAE) No. 16 (effective June 15, 2011.)

3. *Internal Controls*

The Investment Officers are responsible for establishing, maintaining and documenting an internal control structure designed to ensure that the assets of Alameda CTC are protected from loss, theft or misuse. The controls shall be designed to prevent the loss of public funds arising from fraud, employee error, misrepresentation by third parties, unanticipated changes in financial markets, or imprudent actions by employees and officers of Alameda CTC.

VIII. Authorized Investments

The following investments will be permitted by this policy and are those authorized in the California Government Code.

1. United States Treasury notes, bonds, bills, or certificates of indebtedness, or those for which the faith and credit of the United States are pledged for the payment of principal and interest.

   a. Maximum maturity: 5 years
   b. Maximum percent of portfolio: 100%

2. Federal agency or United States government-sponsored enterprise obligations, participations, or other instruments, including those issued by or fully guaranteed as to principal and interest by federal agencies or United States government-sponsored enterprises.

   a. Maximum maturity: 5 years
   b. Maximum percent of portfolio: 100%
   c. Type: Senior and fully guaranteed debt obligations
   d. Maximum per issuer: 35%

3. Repurchase Agreements used solely as short-term investments.

   The following collateral restrictions will be observed: Only U.S. Treasury securities or Federal Agency securities, as described in VIII 1 and 2 above, will be acceptable collateral. All securities underlying Repurchase Agreements must be delivered to Alameda CTC's custodian bank versus payment or be handled under a tri-party repurchase agreement. The total of all collateral for each Repurchase Agreement must equal or exceed, on the basis of market value plus accrued interest, 102 percent of the total dollar value of the money invested by Alameda CTC for the term of the investment. Since the market value of the underlying securities is subject to daily market fluctuations, the investments in repurchase agreements shall be in compliance if the value of the underlying securities is brought back up to 102 percent no later than the next business day. For any Repurchase Agreement with a term of more than one day, the value of the underlying securities must be reviewed on a regular basis.

   Market value must be calculated each time there is a substitution of collateral.

   Alameda CTC or its trustee shall have a perfected first security interest under the Uniform Commercial Code in all securities subject to Repurchase Agreement.

   Alameda CTC may enter into Repurchase Agreements with (1) primary dealers in U.S. Government securities who are eligible to transact business with, and who report to, the Federal Reserve Bank of New York, and (2) California and non-California banking institutions having assets in excess of $25 billion and having debt rated in the highest short-term rating category as provided by a nationally recognized statistical rating organization.

   Alameda CTC will enter into a Master Repurchase Agreement, substantially in the form approved by the Securities Industry and Financial Markets Association

(SIFMA) and by Alameda CTC's counsel, with each firm with which it enters into Repurchase Agreements.

a. Maximum maturity: 90 days
b. Maximum percent of portfolio: 20%

4. Obligations of the State of California or any local agency within the state, including bonds payable solely out of revenues from a revenue-producing property owned, controlled or operated by the state or any local agency or by a department, board, agency or authority of the state or any local agency.

   a. Maximum maturity: 5 years
   b. Maximum percent of portfolio: 10%
   c. Minimum credit quality: A (S&P); or A2 (Moody's); or A (Fitch)
   d. Maximum per issuer: 5%

5. Registered treasury notes or bonds of any of the other 49 states in addition to California, including bonds payable solely out of revenues from a revenue-producing property owned, controlled or operated by the state or by a department, board, agency or authority of any of the other 49 states, in addition to California.

   a. Maximum maturity: 5 years
   b. Maximum percent of portfolio: 10%
   c. Minimum credit quality: A (S&P); or A2 (Moody's): or A (Fitch)
   d. Maximum per issuer: 5%

6. Bankers' Acceptances, otherwise known as bills of exchange or time drafts which are drawn on and accepted by a commercial bank.

   a. Maximum maturity: 180 days
   b. Maximum percent of portfolio: 40%
   c. Minimum credit quality: A-1 (S&P); or P-1 (Moody's); or F-1 (Fitch)
   d. Maximum per issuer: 5%

7. Commercial paper rated in the highest two short-term rating categories, as provided by a nationally recognized statistical rating organization. The entity that issues the commercial paper shall meet all of the following conditions: (a) is organized and operating in the United States as a general corporation; (b) has total assets in excess of five hundred million dollars ($500,000,000); and (c) has debt other than commercial paper, if any, that is rated "A" or higher by a nationally recognized statistical-rating organization.

   a. Maximum maturity: 270 days
   b. Maximum percent of portfolio: ~~25~~40%
   c. Minimum credit quality: A-1 (S&P); or P-1 (Moody's); or F-1 (Fitch)
   d. Maximum per issuer: 5%

No more than 40% of the total portfolio may be invested cumulatively in commercial paper or asset-backed commercial paper as defined in Section 8 below. No more than 10% of the outstanding commercial paper of any single issuer may be purchased. No more than 10% of the total portfolio may be invested in the commercial paper and medium-term notes of a single issuer.

8. Asset-backed commercial paper of "prime" quality and issued by an entity organized within the United States as a special purpose corporation, trust, or limited liability company. The entity that issues the asset-backed commercial paper must meet all of the following conditions: (a) is rated "A-1" (or the equivalent) or higher by at least one nationally recognized statistical rating organization; and (b) has programwide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

a. Maximum maturity: 270 days
b. Maximum percent of portfolio: 40%
c. Minimum credit quality: A-1 (S&P); or P-1 (Moody's); or F-1 (Fitch)
d. Maximum per issuer: 5%

No more than 40% of the total portfolio may be invested cumulatively in asset-backed commercial paper or commercial paper as defined in Section 7 above. No more than 10% of the outstanding commercial paper of any single issuer may be purchased. No more than 10% of the total portfolio may be invested in the commercial paper and medium-term notes of a single issuer.

~~8.~~9. Medium-term notes, defined as all corporate and depository institution debt securities with a maximum remaining maturity of five years or less, issued by corporations organized and operating within the United States or by depository institutions licensed by the U.S. or any state and operating within the U.S. Medium-term corporate notes shall be rated a minimum of "A" or its equivalent by a nationally recognized statistical rating organization.

a. Maximum maturity: 5 years
b. Maximum percent of portfolio: 30%
c. Minimum credit quality: A (S&P); or A2 (Moody's); or A (Fitch)
d. Maximum per issuer: 5%

No more than 10% of the total portfolio may be invested in the medium-term notes and commercial paper of a single issuer.

~~9.~~10. Asset-backed securities, including any consumer receivable pass-through certificate, equipment lease-backed certificate, consumer receivable backed bond, or other pay-through bond with a maximum maturity of five years or less. Asset-backed securities shall be rated "AAA" or its equivalent or better by a nationally recognized statistical rating organization.

a. Maximum Maturity: 5 years
b. Maximum percent of portfolio: 20%

c. Minimum credit quality: AAA (S&P); or Aaa (Moody's); or AAA (Fitch)
d. Maximum per issuer: 5%

~~10.~~11. FDIC insured or fully collateralized time certificates of deposit in financial institutions located in California.

a. Maximum maturity: 1 year
b. Maximum percent of portfolio: 10%
c. Maximum per issuer: 5%

~~11.~~12. Negotiable certificates of deposit or deposit notes issued by a nationally or state-chartered bank, a savings association or a federal association, a state or federal credit union, or by a federally licensed or state-licensed branch of a foreign bank.

a. Maximum maturity: 3 years
b. Maximum percent of portfolio: 30%
c. Minimum credit quality: A (S&P); or A2 (Moody's); or A (Fitch)
d. Maximum per issuer: 5%

~~12.~~13. State of California Local Agency Investment Fund (LAIF)

Although LAIF may invest in securities not permitted in the Alameda CTC's Investment Policy, such investments shall not exclude LAIF from the Alameda CTC's list of eligible investments, provided that LAIF's periodic reports allow the Investment Officer to adequately assess the risk inherent in LAIF's portfolio. Funds invested in LAIF will follow LAIF policies and procedures.

a. Maximum dollar limit: as determined by LAIF

The LAIF portfolio shall be reviewed annually in order to monitor its continuing suitability as an investment option for the Alameda CTC.

~~13.~~14. The California Asset Management Program (CAMP)

a. Maximum dollar limit: double the LAIF limit

The CAMP shall be reviewed annually in order to monitor its continuing suitability as an investment option for Alameda CTC. Funds invested in CAMP will follow CAMP policies and procedures.

~~14.~~15. Shares of beneficial interest issued by diversified management companies that are money market funds registered with the Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. Sec. 80a-1, et seq.). To be eligible for investment pursuant to this subdivision, these companies shall either: (1) attain the highest ranking or the highest letter and numerical rating provided by not less than two nationally recognized statistical rating organizations; or (2) retain an investment advisor registered or exempt from

registration with the Securities and Exchange Commission with not less than five years experience managing money market mutual funds with assets under management in excess of five hundred million dollars ($500,000,000).

a. Maximum percent of portfolio: 20%
b. Maximum per Prime Money Market Fund: 5%
c. Maximum per Government Money Market Fund: 10%
d. Minimum credit quality: AAAm (S&P); or Aaa-mf (Moody's); AAAmmf (Fitch)

~~15.~~16. United States dollar denominated senior unsecured unsubordinated obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank and eligible for purchase and sale within the United States.

a. Maximum maturity: 5 years
b. Maximum percent of portfolio: 10%
c. Minimum credit quality: AA (S&P); or Aa (Moody's); or AA (Fitch)

Important Notes:

a) The percentage limitation for all categories of investments and individual issuers refers to the percentage in the overall Alameda CTC portfolio on the date the security or shares are purchased as measured by the settlement date.

b) The credit rating requirements of this Investment Policy shall apply at the time of purchase. If the credit rating of a security is downgraded below the minimum required rating level for a new investment of that security type subsequent to its purchase, the investment advisor shall promptly notify the Investment Officer. The Investment Officer shall evaluate the downgrade on a case-by-case basis in order to determine if the security should be held or sold. The Investment Officer will apply the general objectives of safety, liquidity, yield and legality to make the decision.

IX. Ineligible Investments

Any security type or structure not specifically approved by this policy is hereby specifically prohibited. Security types which are thereby prohibited include, but are not limited to:

1. "Complex" derivative structures such as range notes, dual index notes, inverse floaters, leveraged or de-leveraged floating-rate notes, or any other complex variable-rate or structured note;

2. Interest-only strips that are derived from a pool of mortgages, or any security that could result in zero interest accrual if held to maturity except for the purchase of securities issued or backed by the United States government in the event of, and for the duration of, a period of negative market interest rates;

3. Non-agency mortgage-backed pass-through securities;

4. Other non-agency mortgage-backed securities; and

5. Non-agency collateralized mortgage obligations.

X. Investment Parameters

1. Credit Risk – Credit risk is the risk that a security or a portfolio will lose some or all of its value due to a real or perceived change in the ability of the issuer to repay its debt. The diversification requirements included in Section VIII are designed to mitigate credit risk. Alameda CTC shall additionally mitigate credit risk by adopting the following diversification strategies:

    a. Avoiding overconcentration in any one issuer or business sector;

    b. Limiting investments in securities with higher credit risks; and

    c. Maintaining a portion of the portfolio in a highly liquid investment such as LAIF

2. Market Risk - Market risk is the risk that the portfolio will fluctuate due to changes in the general level of interest rates. Alameda CTC recognizes that, over time, longer-term portfolios have the potential to achieve higher returns. On the other hand, longer-term portfolios have higher volatility of return. Alameda CTC shall mitigate market risk by providing adequate liquidity for short-term cash needs, and by making some longer-term investments only with funds that are not needed for current cash flow purposes. Alameda CTC further recognizes that certain types of securities, including variable rate securities, securities with principal paydowns prior to maturity, and securities with embedded options, will affect the market risk profile of the portfolio differently in different interest rate environments. Alameda CTC, therefore, adopts the following strategies to control and mitigate its exposure to market risk:

    a. Alameda CTC shall invest in securities with varying maturities, maintaining a minimum of three months of budgeted operating expenditures in short term investments to provide sufficient liquidity for expected disbursements;

    b. The maximum percent of callable securities in the portfolio shall be 25%;

    c. The maximum stated final maturity of individual securities in the portfolio shall be five years, except as otherwise stated in this policy;

    d. Liquidity funds will be held in LAIF, CAMP or in money market instruments maturing within one year or less or held in securities with maturities matched to anticipated expenditures;

    e. Longer term/Core funds will be defined as the funds in excess of liquidity requirements. The investments in this portion of the porfolio will have maturities between 1 day and 5 years and will only be invested in higher quality and liquid securities; and

f. The duration of the Core or benchmarked portion of the portfolio shall at all times be approximately equal to the duration of a Market Benchmark Index selected by Alameda CTC based on Alameda CTC's investment objectives, constraints and risk tolerances, plus or minus 25%. ~~Duration flexibility is necessary because of the short-term benchmarks utilized on the portfolio due to capital project cashflow demands.~~

3. Maximum percentages for a particular issuer or investment type may be exceeded at a point in time subsequent to the purchase of a particular issuer or investment type. Securities need not be liquidated to realign the portfolio; however, consideration should be given to this matter when future purchases are made to ensure that appropriate diversification is maintained.

XI. Performance and Program Evaluation

The investment portfolio will be managed in accordance with the parameters specified within this policy. The portfolio should obtain a market average rate of return during a market/economic environment of stable interest rates. A series of appropriate benchmarks shall be established against which portfolio performance shall be compared on a regular basis. The benchmarks shall be reflective of the actual securities being purchased and risks undertaken and the benchmarks shall have a similar weighted average maturity and credit profile commensurate with investment risk constraints and liquidity needs of Alameda CTC.

Alameda CTC may periodically update the performance benchmarks to reflect current investment objectives and constraints and shall communicate such changes to the investment advisor.

Appendix I

AUTHORIZED INVESTMENTS SUMMARY TABLE

INVESTMENT	% OF PORTFOLIO		PURCHASE RESTRICTIONS	MAXIMUM MATURITY		MINIMUM CREDIT QUALITY	
	Per Cal. Gov't Code	Alameda CTC Policy	Alameda CTC Policy	Per Cal. Gov't Code	Alameda CTC Policy	Per Cal. Gov't Code	Alameda CTC Policy
U.S. Treasury Notes, Bonds, Bills or Certificates of Indebtedness	100%	100%	None	5 years	5 years	NA	NA
Federal or U.S. Sponsored Obligations fully guaranteed by Federal Agencies or U.S. Government Sponsored Enterprises	100%	100%	Max 35% per issuer	5 years	5 years	NA	Senior and Fully Guaranteed Debt
Repurchase Agreements	NA	20%	Strict collateral requirements; Master Repurchase Agreement	1 year	90 days	NA	NA
State of California and California Local Agency Bonds	NA	10%	Max 5% per issuer	5 years	5 years	NA	A (S&P) or A2 (Moody's) or A (Fitch)
Bonds of any of the other 49 states in addition to California	NA	10%	Max 5% per issuer	5 years	5 years	NA	A (S&P) or A2 (Moody's) or A (Fitch)
Bankers' Acceptances	40%	40%	Max 5% per issuer	180 days	180 days	NA	A-1 (S&P) or P-1 (Moody's) or F-1 (Fitch)

INVESTMENT	% OF PORTFOLIO		PURCHASE RESTRICTIONS	MAXIMUM MATURITY		MINIMUM CREDIT QUALITY	
	Per Cal. Gov't Code	**Alameda CTC Policy**	**Alameda CTC Policy**	**Per Cal. Gov't Code**	**Alameda CTC Policy**	**Per Cal. Gov't Code**	**Alameda CTC Policy**
Commercial paper of U.S. corporations with total assets exceeding $500,000,000	~~25~~40%	~~25~~40%	Max ~~5~~10% of outstanding paper of any single issuer & max 5% of portfolio of any one issuer	270 days	270 days	A-1 or P-1 or F-1	A-1 (S&P) or P-1 (Moody's) or F-1 (Fitch)
Asset-backed commercial paper issued by entities organized in the U.S.	40%	40%	Max 10% of outstanding paper of any single issuer & max 5% of portfolio of any one issuer	270 days	270 days	A-1 or P-1 or F-1	A-1 (S&P) or P-1 (Moody's) or F-1 (Fitch
Medium Term Corporate Notes of U.S. Corporations	30%	30%	Max 5% per issuer	5 years	5 years	A	A (S&P) or A2 (Moody's) or A (Fitch)
Asset-Backed Securities	20%	20%	Max 5% per issuer	5 years	5 years	AA	AAA (S&P) or Aaa (Moody's) or AAA (Fitch)
California Collateralized Time Deposits	NA	10%	Max 5% per issuer	NA	1 year	NA	NA
Negotiable Certificate of Deposits	30%	30%	Max 5% per issuer	5 years	3 years	NA	A (S&P) or A2 (Moody's) or A (Fitch)
State of California- Local Agency Investment Fund (LAIF)	NA	NA	As limited by LAIF	NA	NA	NA	NA
California Asset Management Program	NA	NA	Double the LAIF limit	NA	NA	NA	NA
Shares of Beneficial Interests (Money Market Funds)	20%	20%	Max 5% per Prime fund, Max 10% per Government fund	NA	N/A	AAA	AAAm (S&P) or Aaa-mf (Moody's) or AAAmmf (Fitch)

INVESTMENT	% OF PORTFOLIO		PURCHASE RESTRICTIONS	MAXIMUM MATURITY		MINIMUM CREDIT QUALITY	
	Per Cal. Gov't Code	**Alameda CTC Policy**	**Alameda CTC Policy**	**Per Cal. Gov't Code**	**Alameda CTC Policy**	**Per Cal. Gov't Code**	**Alameda CTC Policy**
Obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank	30%	10%	NA	5 years	5 years	AA	AA (S&P) or Aa (Moody's) or AA (Fitch)

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DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Administration Jeannie Chen, Director of Finance
SUBJECT:	Approve Measure B and Measure BB Sales Tax Budget Update for FY2020-21

Recommendation

It is recommended that the Commission approve:

- An increase to the Alameda CTC Measure B sales tax revenue budget for FY2020-21 from the currently adopted amount of $145.0 million to $155.0 million for an increase of $10.0 million and an increase in the corresponding direct local distribution expenditures based on the formulas established in the 2000 transportation expenditure plan, and
- An increase to the Alameda CTC Measure BB sales tax revenue budget for FY2020-21 from the currently adopted amount of $145.0 million to $155.0 million for an increase of $10.0 million and an increase in the corresponding direct local distribution expenditures based on the formulas established in the 2014 transportation expenditure plan.

Summary

The proposed Measure B and Measure BB revenue increases to the budget are 6.9 percent higher than the currently adopted budget. Based on receipts to date, sales tax revenues are projected to out-perform the conservative projection in the budget proposed during the height of the pandemic by at least 6.9 percent. Overall receipts for the first half of the fiscal year were higher than budget by about 10.4 percent and generally came in slightly higher in the first half of the fiscal year mostly due to holiday spending. This revised projection brings the agency much closer to the projections for last fiscal year before the pandemic hit of $320 million, which still is not as high as the agency's historical peak collection level of $334 million which occurred in FY2018-19. These revised sales tax projections will be included as a budget adjustment to the FY2020-21 budget, increasing projected revenues overall by $20.0 million and the corresponding direct local distribution (DLD) budgeted expenditures based on the formulas established in the 2000 and 2014 transportation expenditure plans.

Background

An adjustment to sales tax revenues in the budget is not always necessary once it has been established, however, when actual revenues are coming in higher than budget, it is imperative that we ensure that the Agency has adequate legal expenditure authority to allow for the transfer of all DLD funds to the member agencies as sales tax revenues are collected. For this reason, staff recommends the Commission adopt this sales tax revenue budget update for FY2020-21.

Fiscal Impact: The fiscal impact of approving the proposed FY2020-21 sales tax revenue and expenditure budget update would be to provide additional resources of $20.0 million and authorize the corresponding DLD expenditures to member agencies based on the formulas established in the 2000 and 2014 transportation expenditure plans.

DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Admin. Jeannie Chen, Director of Finance
SUBJECT:	Approve the Alameda CTC FY2021-22 Proposed Budget

Recommendation

It is recommended that the Commission approve the Alameda CTC Proposed Budget for FY2021-22.

Summary

The Alameda CTC FY2021-22 Proposed Consolidated Budget (Proposed Budget) demonstrates a sustainable, balanced budget utilizing projected revenues and fund balance in some funds to fund total expenditures. The Proposed Budget has been prepared based on the modified accrual basis of accounting, which is consistent with the basis of accounting utilized to prepare the agency's audited financial statements. It has been segregated by fund type and includes an adjustment column in order to eliminate interagency revenues and expenditures on a consolidated basis. The fund types included are General Funds, Express Lanes Fund, Special Revenue Funds, Exchange Fund, Debt Service Fund, and Capital Projects Funds.

The Proposed Budget is summarized in Attachment A of this staff report. The FY2021-22 budget contains projected revenues totaling $360.2 million and anticipated expenditures of $306.9 million. Salaries and benefits expenditures are nominal as compared to total budgeted expenditures. These revenue and expenditure totals constitute a net increase in fund balance of $53.3 million and a projected consolidated ending fund balance of $419.6 million.

The proposed budget assumes a short-term, inter-fund loan of up to $125.0 million from the 1986 Measure B Capital Fund to the Measure BB Capital program, which would delay the need for external financing for the Measure BB Capital program to FY2022-23 based on most recent cash flow projections.

Approval of the Proposed Capital Program budget is requested for the total amount found in the "Proposed FY2021-22 Capital Budget w/ Estimated Rollover" column on the attached FY2021-22 Proposed Capital Programs Budget sheet (Attachment B). This column includes both the additional capital budget amount requested for FY2021-22 as well as an estimated rollover balance from the adopted FY2020-21 budget. The capital program amount carried forward to the Alameda CTC FY2021-22 Proposed Consolidated Budget sheet (Attachment A) does not include the roll forward budget authority because the expenditure amount is still included in the approved budget for FY2020-21 and, therefore, is already netted out of the projected roll forward fund balance from the FY2020-21 adopted budget. During the mid-year budget update process, the roll forward fund balance will be updated to actual based on audited financial statements. Consequently, the capital program budget amount on the FY2021-22 Proposed Consolidated Mid-Year Budget Update spreadsheet, which will come to the Commission for approval later in FY2021-22, will be for the full capital budget including both the actual roll forward balance from FY2020-21 and any additional requested capital budget for FY2021-22. This methodology is necessary to ensure accurate and reliable fund balance information in the Alameda CTC budget.

The Proposed Budget includes revenues and expenditures necessary to provide vital programs and planning projects for Alameda County and to deliver significant capital projects that expand access and improve mobility in Alameda County consistent with the Comprehensive Investment Plan (CIP).

In January 2014, the Commission adopted a General Fund Balance Reserve Policy to conform to best practices in mitigating risk for the agency. The policy was developed in accordance with best practice recommendations by the Government Finance Officers' Association. Alameda CTC has included the General Fund balance reserve amount in this budget, which is calculated based on 2 months' worth of expenditures in the General Fund and 1 months' worth of expenditures in all other funds and amounts to $28.6 million. The Express Lanes Fund includes a maintenance reserve carried over from prior years of $5.0 million, and the operational risk reserve in this fund remains at the goal level of $20.0 million, which was established in the approved I-580 Express Lane 20 Year Expenditure Plan. The reserves in this budget are in line with best practices and are necessary to ensure financial stability and the ability to fund maintenance when needed on the I-580 Express Lanes and to cover unanticipated expenses, such as those related to commitments in the operations and maintenance agreement with Caltrans, and loss of revenue due to unexpected events such as the COVID-19 pandemic, catastrophic failure of the toll lane systems, or a natural disaster, which are not covered by insurance. This budget also allows for the I-580 Express Lanes Fund to begin to pay back the loan from 2000 Measure B used to construct the lane. The total amount of all reserves in the Proposed Budget is $48.6 million which is 9.3 percent of total expenditures including the roll forward capital budget.

Background

Development of the Proposed Budget for FY2021-22 focused on the mission and core functions of Alameda CTC that will enable Alameda CTC to plan, fund and deliver

transportation programs and projects that expand access and improve mobility in Alameda County. It includes funding for:

- Critical planning activities to implement accessible, affordable, and equitable multimodal projects,
- Programming activities for various internal and external funds under purview of the Alameda CTC to advance projects, programs and policies that support sustainable transportation, reducing emissions and increasing mobility options, and
- Delivery of multimodal projects to support investments in active transportation, economic vitality, jobs, safety and access in Alameda County.

The Proposed Budget includes funding for all approved agency positions filled or planned to be filled in FY2021-22. Salaries and benefits in the Proposed Budget account for 1.69 percent of budgeted expenditures including roll forward capital budget authority.

The 2000 Measure B and 2014 Measure BB Salary and Benefits Limitation ratio and the Administrative Cost Limitation ratio were calculated based on the revenues and expenditures in the Proposed Budget and were found to be compliant with requirements in the Transportation Expenditure Plans and the Public Utility Code.

Fiscal Impact: The fiscal impact of the FY2021-22 Proposed Consolidated Budget will be to provide resources of $360.2 million and authorize expenditures of $306.9 million, with an overall increase in fund balance of $53.3 million for a projected ending fund balance of $419.6 million.

Attachments:

A. Alameda CTC FY2021-22 Proposed Consolidated Budget
B. Alameda CTC FY2021-22 Proposed Capital Programs Budget

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Alameda County Transportation Commission
FY2021-22 Proposed Consolidated Budget

	General Funds	Express Lanes Fund	Special Revenue Funds	Exchange Fund	Debt Service Fund	Capital Project Fund	Inter-Agency Adjustments/ Eliminations	Total
Projected Beginning Fund Balance:	$ 89,631,179	$ 29,326,279	$ 138,141,301	$ 5,868,846	$ 9,822,864	$ 93,492,042	$ -	$ 366,282,511
Revenues:								
Sales Tax Revenues	$ 13,155,000	$ -	$ 197,519,940	$ -	$ -	$ 103,325,060	$ -	$ 314,000,000
Investment Income	210,000	115,000	390,000	45,000	2,500	670,000		1,432,500
Member Agency Fees	1,550,368	-	-	-	-	-		1,550,368
VRF Funds	-	-	12,000,000	-	-	-		12,000,000
TFCA Funds	-	-	2,395,951	-	-	-	-	2,395,951
Toll Revenues	-	7,500,000	-	-	-	-		7,500,000
Toll Violation and Penalty Revenue	-	1,500,000	-	-	-	-		1,500,000
Other Revenues	-	-	13,100	-	26,473,200	-	(26,486,300)	-
Regional/State/Federal Grants	3,106,229	-	3,024,172	-	-	11,200,000	-	17,330,400
Local and Other Grants	-	-	-	42,109	-	2,413,000	-	2,455,109
Total Revenues	18,021,597	9,115,000	215,343,163	87,109	26,475,700	117,608,060	(26,486,300)	360,164,329
Expenditures:								
Administration								
Salaries and Benefits	2,791,195	-	-	-	-	8,565		2,799,760
General Office Expenses	2,313,000	-	400	-	-	9,300	(400)	2,322,300
Travel Expense	32,000	-	-	-	-	-	-	32,000
Debt Service	-	-	-	-	26,473,200	26,473,200	(26,473,200)	26,473,200
Professional Services	2,472,271	-	-	-	-	225,000	-	2,697,271
Commission and Community Support	222,700	-	12,700	-	-	-	(12,700)	222,700
Contingency	500,000	-	-	-	-	-		500,000
Freeway Operations								
Salaries and Benefits	-	326,590	-	-	-	-		326,590
Operating Expenditures	-	6,233,920	-	-	-	-	-	6,233,920
Special Project Expenditures	-	5,375,000	-	-	-	-		5,375,000
Planning								
Salaries and Benefits	1,656,091	-	-	-	-	-		1,656,091
Programs								
Salaries and Benefits	134,425	-	2,452,370	42,109	-	-	(97,202)	2,531,703
Programs Management and Support	400,000	-	2,038,132	-	-	-		2,438,132
Safe Routes to School Programs	-	-	3,127,441	-	-	-	-	3,127,441
VRF Programming	-	-	9,303,473	-	-	-	-	9,303,473
Measure B/BB Direct Local Distribution	-	-	161,658,967	-	-	-		161,658,967
Grant Awards	-	-	12,267,536	-	-	-	-	12,267,536
TFCA Programming	-	-	2,702,668	-	-	-	-	2,702,668
Capital Projects								
Salaries and Benefits	-	12,396	-	-	-	1,602,196	(87,243)	1,527,349
Capital Project Expenditures	-	(10,496,107)	6,677,424	-	-	66,486,259	-	62,667,575
Indirect Cost Recovery/Allocation								
Indirect Cost Recovery from Capital, Spec Rev & Exch Funds	(184,445)	-	-	-	-	-	184,445	-
Total Expenditures	10,337,237	1,451,799	200,241,110	42,109	26,473,200	94,804,520	(26,486,300)	306,863,676
Net Change in Fund Balance	7,684,360	7,663,201	15,102,052	45,000	2,500	22,803,540	-	53,300,653
Projected Ending Fund Balance	$ 97,315,539	$ 36,989,480	$ 153,243,353	$ 5,913,846	$ 9,825,364	$ 116,295,582	$ -	$ 419,583,164
Freeway Maintenance Contributions	-	5,000,000	-	-	-	-	-	5,000,000
Fund Balance/Operational Reserves	28,640,601	20,000,000	-	-	-	-	-	48,640,601
Loan Repayment I-580 EL to MB	-	11,989,480	-	-	-	-	-	11,989,480
Projected Net Fund Balance	$ 68,674,938	$ -	$ 153,243,353	$ 5,913,846	$ 9,825,364	$ 116,295,582	$ -	$ 353,953,083

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Alameda CTC
Fiscal Year 2021-22
Proposed Capital Programs Budget

Capital Programs	(A) Adopted FY 2020-21 Capital Budget	(B) Estimated FY 2020-21 Expenditures	(A) - (B) = (C) Estimated FY 2020-21 Rollover to FY 2021-22	(D) Proposed FY 2021-22 Capital Budget Request	(C) + (D) = (E) Proposed FY 2021-22 Capital Budget w/ Estimated Rollover	Funding			
						Total Local	Total Regional	Total State	Total Federal
1986 Measure B Capital Program	$ 5,460,506	$ 560,000	$ 4,900,506	$ 1,400,000	$ 6,300,506	$ 6,300,506	$ -	$ -	$ -
2000 Measure B Capital Program	62,223,130	17,025,209	45,197,921	(16,206)	45,181,715	45,181,715	-	-	-
2014 Measure BB Capital Program	275,188,360	146,087,894	129,100,466	64,292,000	193,392,466	150,223,620	9,000,000	31,770,413	2,398,434
2014 Measure BB SRF Discretionary Capital Program	18,734,694	8,431,781	10,302,913	6,677,424	16,980,336	16,980,336	-	-	-
Non-Sales Tax Capital Program	7,644,494	2,301,883	5,342,611	2,412,661	7,755,272	4,284,266	1,877,814	1,593,192	-
Non-Sales Tax Exchange Fund Capital Program	8,897,319	1,800,000	7,097,319	-	7,097,319	7,097,319			
Non-Sales Tax SRF Capital Program	985,002	-	985,002	-	985,002	985,002	-	-	-
Express Lanes Capital Program	14,858,858	-	14,858,858	(10,483,711)	4,375,147	4,375,147	-	-	-
	$ 393,992,365	$ 176,206,767	$ 217,785,597	$ 64,282,168	$ 282,067,765	$ 235,427,912	$ 10,877,814	$ 33,363,605	$ 2,398,434

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DATE:	May 3, 2021
TO:	Finance and Administration Committee
FROM:	Patricia Reavey, Deputy Executive Director of Finance and Administration
SUBJECT:	Approve and adopt restatements of the Alameda CTC Cafeteria Plan

Recommendation

It is recommended that the Commission approve and adopt restatements of the Alameda CTC Cafeteria Plan (the Plan), one each for calendar year 2020 and calendar year 2021. If approved by the Commission, the restated Cafeteria Plan for 2020 would technically be effective January 1, 2020, and the restated Cafeteria Plan for 2021 would technically be effective January 1, 2021. These changes are proposed in response to COVID-19 related relief in accordance with the Consolidated Appropriations Act, 2021 IRS Notice 2021-15 and the American Rescue Plan of 2021 which were enacted to provide economic relief to families.

Summary

The Plan was established by Alameda CTC in 2012 to permit eligible employees to pay for their share of contributions for benefits on a pre-tax basis, and to contribute on a pre-tax salary reduction basis to an account for reimbursement of eligible medical care expenses, referred to as a Flexible Spending Account or and FSA, and/or an account for reimbursement of certain dependent care expenses, referred to as a Dependent Care Assistance Program or a DCAP. This Cafeteria Plan is a qualified plan under Code Section 125 and is administered as such.

The updates outlined in Attachment A are specific to the 2020 plan year, and those in Attachment B are specific the 2021 plan year. These changes are proposed in response to COVID-19 related relief in accordance with the Consolidated Appropriations Act, 2021 IRS Notice 2021-15 and the American Rescue Plan of 2021 which were enacted to provide economic relief to families.

In summary, the updates include the following, as outlined in Attachment A, for the 2020 plan year:

- An extended grace period during which employees and employees terminated during 2020 can make claims for reimbursement of expenses incurred through December 31, 2021 if submitted by April 30, 2022, up to the amount the employee has set aside through payroll deductions for medical expenses and/or dependent care expenses through the end of the plan year or their termination date,
- Allows for a tax dependent of the participant who attains age thirteen during 2020 to be considered a qualifying individual as it pertains to the DCAP, and
- Other administrative clean-up of plan language.

In summary, the updates include the following, as outlined in Attachment B, for the 2021 plan year:

- An extended grace period during which employees and employees terminated during 2021 can make claims for reimbursement of expenses incurred through December 31, 2022 if submitted by April 30, 2023, up to the amount the employee has set aside through payroll deductions for medical expenses and/or dependent care expenses through the end of the plan year or their terminations date,
- Allows for a tax dependent of the participant who attains age thirteen during 2021 to be considered a qualifying individual as it pertains to the DCAP,
- Allows for limited mid-year changes to participant's salary reduction elections, and
- Doubles the maximum election amount allowed on the FSA, going from $2,500 to $5,000, and on the DCAP, going from $5,250 to $10,500.

Alameda CTC recommends these updates to the Plan to allow staff to take advantage of the relief intended by the Consolidated Appropriations Act and the American Rescue Plan Act of 2021.

Background

Alameda CTC adopted the Plan in 2012 to permit eligible employees to pay for their share of contributions for benefits on a pre-tax basis, and to contribute on a pre-tax salary reduction basis to an account for reimbursement of eligible medical care expenses and/or an account for reimbursement of certain dependent care expenses. The Plan has not been amended or restated since that time.

In response to the COVID-19 pandemic with the goal of providing economic relief to families, the Consolidated Appropriations Act 2021 was enacted in December 2020, and the American Rescue Plan Act of 2021 was enacted in January 2021 (the Acts), for which the Internal Revenue Service issued Notice 2021-15 in February to clarify guidance. These Acts allow for the updates recommended in Attachment A and Attachment B. Because the Acts apply different rules to the 2020 plan year versus the 2021 plan year, the changes have been shown in two separate documents for which the Plan restated as of January 1, 2021

(Attachment B) will replace the Plan restated as of January 1, 2020 (Attachment A) automatically when appropriate.

The recommend updates to the Plan make the benefit to employees more generous due to its pretax nature, but since all reimbursements are made from funds that have been set aside through payroll deductions from participants, it does not increase the cost to the agency.

Fiscal Impact: There is no fiscal budget impact related to the approval and adoption of the restated Cafeteria plans.

Attachments:

A. Alameda County Transportation Commission Cafeteria Plan As Restated Effective January 1, 2020 (Draft Restatement in Redline)
B. Alameda County Transportation Commission Cafeteria Plan As Restated Effective January 1, 2021 (Draft Restatement in Redline)
C. Resolution Approving and Adopting Restated Cafeteria Plans for Calendar Years 2020 and 2021

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ALAMEDA COUNTY TRANSPORTATION COMMISSION
CAFETERIA PLAN

As ~~Adopted~~Restated Effective ~~February~~January 1, ~~2012~~2020

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ALAMEDA COUNTY TRANSPORTATION COMMISSION
CAFETERIA PLAN

As ~~Adopted~~Restated Effective ~~February~~January 1, ~~2012~~2020

ARTICLE I. Introduction

1.1 Establishment of Plan

Alameda County Transportation Commission (the Employer) hereby ~~establishes the~~restates Alameda County Transportation Commission Cafeteria Plan (the Plan) effective ~~February~~January 1, ~~2012~~2020 (the Effective Date~~). ~~) to incorporate applicable COVID-19 related relief in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15. The Plan was established effective as of February 1, 2012.~~ Capitalized terms used in this Plan that are not otherwise defined have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of contributions for the Benefit Plan Options in Appendix A on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an Employee's account for reimbursement of certain Medical Care Expenses (Health FSA Account) and/or to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan under Code Section 125 and will be interpreted and administered consistent with the requirements of Code Section 125 and the regulations issued thereunder.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code Section 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b). The DCAP Component is intended to qualify as a dependent care assistance program under Code Section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of HIPAA and COBRA. In the event that the Health FSA Component is determined not to be a separate plan, the Plan will be designated as a hybrid entity for purposes of HIPAA, such that it will be a covered entity only with respect to the Health FSA Component.

ARTICLE II. Definitions

2.1 Definitions

Account(s) means the Health FSA Accounts and the DCAP Accounts described in Sections 7.5 and 8.5.

Benefit Plan Option means a qualified benefit under Code Section 125(f) that is available to a Participant under this Plan as set forth in Appendix A, as amended from time to time. The Employer may substitute, add, subtract, or revise at any time the menu of such Benefit Plan Options and/or the benefits, terms, and conditions of any such options or plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Board of Directors means the Board of Commissioners of the Alameda County Transportation Commission.

Change in Status means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986 and the Treasury Regulations issued thereunder, as amended.

Compensation means the cash wages or salary paid to an Employee by the Employer.

DCAP means dependent care assistance program.

DCAP Account means the account described in Section 8.5.

DCAP Benefits has the meaning described in Section 8.1.

DCAP Component means the component of this Plan described in Article VIII.

Dependent means: (a) for purposes of accident or health coverage, (1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code Section 152(f)(1) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any National Medical Support Order, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 8.3.

Earned Income will have the meaning given such term in Code Section 129(e)(2).

Effective Date of this Plan means ~~February~~January 1, ~~2012~~2020.

Election Form/Salary Reduction Agreement means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Benefit Plan Options(s) and authorizing Salary Reductions to pay for any of the Benefit Plan Options.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Section 3.1.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; and (c) any employee covered under a collective bargaining agreement, unless that agreement provides for the employee's participation in the Plan. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for a limited duration following termination of employment provided any required contributions are made and only to the extent specifically provided under this Plan.

Employer means the Alameda County Transportation Commission.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Grace Period means 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. Notwithstanding the foregoing, for purposes of the Plan Year ending December 31, 2020, the Grace Period is the period from January 1, 2021 through December 31, 2021. (Note: For purposes of the DCAP, as the Grace Period is available pursuant to the relief provided in the Consolidated Appropriations Act, 2021, the Grace Period is available for amounts in DCAP Accounts that remain as of December 31, 2020 only. The Grace Period is available under the Health FSA irrespective of the relief.)

Health FSA means the health flexible spending arrangement.

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Plan(s) means the plan(s) that the Employer maintains for its Employees (and for their Spouses, same-sex spouses, domestic partners, and Dependents that may be eligible under the terms of such plan), which provide benefits through a group insurance policy or policies (e.g., medical, dental and vision insurance). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Medical Care Expenses has the meaning described in Section 7.3.

Nonelective Contribution(s) means any amount that the Employer, in its sole discretion, may contribute under the Plan to provide benefits for individual Participants and their Spouses, Dependents, domestic partners, and same-sex spouses, as applicable, under one or more of the Benefit Plan Options offered under the Plan.

Open Enrollment Period means the period during the Plan Year during which Eligible Employees may elect to participate in the Plan or make changes to their elections for the next Plan Year. The Employer will determine this period each Plan Year, which the Plan Administrator will make known in the Plan's open enrollment materials.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include those who elect one or more Benefit Plan Options under the Plan.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date on which participation commences, as described in Section 4.2; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.3.

Plan means the Alameda County Transportation Commission Cafeteria Plan as set forth herein, as amended from time to time.

Plan Administrator means the person(s), entity, or committee as may be appointed from time to time by the Board of Directors (or its authorized designee) to administer the Plan. If no such person, entity, or committee is appointed, the Plan Administrator is the Employer.

Plan Sponsor means the Employer.

Plan Year means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year will be the entire short plan year.

Premium Payment Benefits means the Premium Payment Benefits described in Section 6.1.

Premium Payment Component means the component of this Plan described in Article VI.

Qualifying Dependent Care Services has the meaning described in Section 8.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1); (b) a tax dependent of the Participant as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child will, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and will not be treated as a Qualifying Individual with respect to the noncustodial parent. Furthermore, notwithstanding the foregoing, in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15 and subject to Section 8.6, for purposes of the 2020 Plan Year, the term "Qualifying Individual" shall also include a tax dependent of the Participant as defined in Code Section 152(a)(1) who attains the age of thirteen (13) at any time during the 2020 calendar year, who has the same principal place of abode as the Participant for more than one-half of the Plan Year, and who has not provided over one-half of his or her own support for the Plan Year.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. A domestic partner or same-sex spouse is not treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCAP Component the term Spouse does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

All full-time Employees are eligible to participate in the Plan. To become a Participant, an Eligible Employee must make a timely election to participate in accordance with Article IV. Eligibility for any Benefit Plan Option will be subject to the requirements specified in the governing plan documents of the applicable Benefit Plan Option. The provisions of this Article are not intended to override any eligibility requirement or waiting period specified in the applicable Benefit Plan Options and the terms of eligibility and participation for any Benefit Plan Option offered under the Plan are subject to the requirements specified in the Benefit Plan Option's governing documents.

3.2 Use of Contributions

As a Participant, an Employee will be permitted to (1) elect Benefit Plan Options for which he or she is eligible, (2) receive available Nonelective Contributions for which he or she is eligible in the manner set forth in the enrollment materials, (3) pay his or her share of the cost of his or her elected benefits with Salary Reduction contributions, and (4) if permitted under the terms of the Benefit Plan Options and uniform rules adopted by the Plan Administrator, pay his or her share of the costs of the elected benefits with after-tax dollars (e.g., if Salary Reduction contributions are not available or are insufficient to pay his or her share of the cost of the Benefit Plan Option). In addition, as a Participant, an Employee may be permitted to elect health coverage for an individual who is not the employee's Spouse or Dependent if permitted under the terms of the Benefit Plan Options and in accordance with uniform rules adopted by the Plan Administrator; provided, however, that the fair market value of such coverage will be included in the Employee's gross income to the extent required by applicable law, and the Employee will be treated as having purchased the coverage with after-tax dollars.

3.3 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the date the Participant makes a permitted election not to participate in the Plan;

(b) the date that the Participant no longer satisfies the eligibility requirements of this Plan or all of the Benefit Plan Options. Notwithstanding the foregoing, for purposes of pre-tax COBRA coverage, certain Employees may continue eligibility for certain periods subject to the restrictions and terms otherwise described in this Plan; or

(c) The date that the Plan is either terminated or amended to exclude the Participant or the class of employees to which the Participant belongs.

Termination of participation in this Plan will automatically revoke the Participant's elections. Benefits under any Insurance Plan will terminate as of the date(s) specified in the Insurance Plan. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for DCAP Benefits. If revocation occurs under this Section 3.3, no new election may be made by such Participant during the remainder of the Plan Year except as set forth in Section 3.4.

3.4 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, or otherwise loses eligibility and then is rehired or becomes eligible once again within 30 days or less after the date of a termination of employment or loss of eligibility, then the Employee will be reinstated with the same elections that such individual had before termination or other loss of eligibility. If a former Participant is rehired more than 30 days following termination of employment or becomes eligible after 30 days following a loss of eligibility and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 4.2. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the applicable Insurance Plan is reinstated.

3.5 FMLA Leaves of Absence

(a) *Health Insurance Benefits*. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health insurance benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the contributions for those benefits under this Plan.

An Employer may require participants to continue all health insurance benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the contributions will be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her health insurance benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue health insurance benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's health insurance benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Premium Payment Component or Health FSA Component as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health insurance benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits, a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such benefits when the Participant is on non-FMLA leave, as described in Section 3.6. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax

basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.6 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the applicable election change rules in Section 10.3 will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Election to Participate

To become a Participant, an Eligible Employee must submit a completed and signed Election Form/Salary Reduction Agreement to the Plan Administrator in the time and in the manner required by the Plan Administrator.

4.2 Elections When First Eligible

(a) *Currently Eligible Employees*. An Employee who is eligible to participate in this Plan as of the Effective Date must complete, sign, and file an Election Form/Salary Reduction Agreement with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan to become a Participant on the Effective Date. The elections made by the Eligible Employee on this initial Election Form/Salary Reduction Agreement will be effective for the Plan Year beginning on the Effective Date.

(b) *New Employees or Newly Eligible Employees*. An Employee who first becomes eligible to participate in the Plan mid-year (and after the Effective Date) may elect to commence participation in the Plan after the eligibility requirements of Section 3.1 have been satisfied by completing, signing, and filing an Election Form/Salary Reduction Agreement with the Plan Administrator in the time and in the manner required by the Plan Administrator. Participation in the Plan will commence on the first day of the month following the Plan Administrator's receipt of a properly completed and signed Election Form/Salary Reduction Agreement. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 10.3. Eligibility for Premium Payment Benefits will be subject to the additional requirements, if any, specified in the applicable Insurance Plans.

4.3 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator will provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to

participate in this Plan. The Election Form/Salary Reduction Agreement will enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it will become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 10.3.

4.4 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.2 and 4.3, then the Employee may not elect any benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 10.3. Notwithstanding any contrary provision in the Plan, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for benefits under an Insurance Plan and has made an effective election for such benefits outside the Plan, then the Employee's share of the contributions for such benefits will automatically be paid with pre-tax dollars and will be deemed a "default election" under the Plan. Such default elections cannot be changed until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 10.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. No default elections are permitted for Health FSA or DCAP Benefits.

4.5 Irrevocability of Elections

Unless an exception applies (as described in Article X), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following benefits:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII.

(c) DCAP Benefits, as described in Article VIII.

In no event will benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article VII. No Grace Period is available for DCAP Benefits.

5.2 Source of Benefit Funding

The cost of coverage under the component Benefit Plan Options will be funded by a Participant's Salary Reductions, Nonelective Contributions provided by the Employer, or a combination of the foregoing. The required contributions for each of the Benefit Plan Options offered under the Plan will be made known to employees in annual enrollment materials. Salary Reduction Contributions that are allocated to any Benefit Plan Option will equal the contributions required from the Participant less any available Nonelective Contributions allocated to that option. A Participant may elect to receive Nonelective Contributions in the form of cash to the extent described in the applicable annual enrollment materials. The maximum amount of employee contributions, plus any Nonelective Contributions made available by the Employer, will not exceed the aggregate cost of the Benefit Plan Options elected.

5.3 Employer Contributions

The Employer may, in its sole discretion, make Nonelective Contributions on behalf of a Participant toward the cost of one or more Benefit Plan Options. The amount of Nonelective Contributions that may be applied towards the cost of each of the Benefit Plan Option(s) for any Participant will be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the Employer's sole discretion. The amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer may prescribe.

No provision of this Plan will be construed to require the Employer or Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made. The Plan does not create a trust in favor of a Participant or any person claiming on a Participant's behalf.

ARTICLE VI. Premium Payment Component

6.1 Benefits

An Eligible Employee can elect to participate in the Premium Payment Component by electing (a) to receive benefits under the Insurance Plans described in Appendix A; and (b) to pay for his or her share of the contributions for those benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision in this Plan, insurance benefits under the Insurance Plans are subject to the terms and conditions of the Insurance Plans, and no changes can be made with respect to such plans (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan.

6.2 Participant Contributions for Cost of Coverage

The annual contribution for a Participant's portion of the Premium Payment Benefits is equal to the amount as set by the Employer in the annual enrollment materials.

6.3 Benefits Provided Under the Insurance Plans

Insurance benefits will be provided by the Insurance Plans in accordance with their governing documents, and not this Plan. The types and amounts of insurance benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of such plans are set forth in their governing documents. All claims to receive benefits under the Insurance Plans will be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance with those plans, as may be amended from time to time.

6.4 Insurance Benefits; COBRA

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 health coverage terminates under an Insurance Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), will be given the opportunity to continue on a self-pay basis the same health coverage that he or she had under the applicable Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage will be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage under an Insurance Plan 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 (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) 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 Insurance Plan benefits will be paid on an after-tax basis (unless as may be otherwise 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).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay his or her contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Participant Contributions for Cost of Coverage of Health FSA Benefits

The annual contribution for a Participant's portion of the Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in the annual enrollment materials.

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force. In addition,

certain individuals may receive reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 7.4(e).

(a) *Incurred*. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses*. "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);
- ~~medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator will have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);~~
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or
- any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

7.4 Maximum and Minimum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage*. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 or is entitled to submit expenses incurred during a Grace Period as provided in Section 7.4(e). Payment will be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or during a Grace

Period, if applicable under Section 7.4(e)), provided that the other requirements of this Article VII have been satisfied. Notwithstanding the foregoing, in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, a Participant whose participation in the Plan terminates in 2020 may continue to receive reimbursements from any contributions that remain in his or her Health FSA as of the date of such termination through the end of the 2020 Plan Year, including any Grace Period

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage will be set forth in the enrollment materials~~.~~, but shall be no more than the contribution limit announced by the IRS for the applicable year. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage is $0. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents will be charged against the Participant's Health FSA Account. ~~In no event will~~Unless otherwise permitted under applicable law, the maximum annual benefit may not exceed the maximum limit provided under ~~federal~~such law.

(c) *Changes; No Proration.* For each Plan Year, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 10.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article X (other than under Section 10.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 10.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 7.4(e), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts") if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.
- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the April 30 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. For purposes of the Grace Period for amounts relating to the 2020 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2021 through December 31, 2021, must be submitted no later than April 30, 2022. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 7.4(e)).

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's

annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement will in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule

(a) *Use-or-Lose Rule*. Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance.

(b) *Use of Forfeitures.* All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred will be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing*. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;

- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Participant's Health FSA Account for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied*. For reimbursement claims that are denied, see the appeals procedure in Article XI.

(d) *Claims Ordering; No Reprocessing*. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which 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 Medical Care Expenses incurred during the Period of Coverage 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 7.4(e)), 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.

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 FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be

eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance 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 in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage will be subject to all conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year in accordance with the provisions of Section 7.4(e).

Contributions for coverage for Health FSA Benefits 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 (a) because the Employee ceases to be eligible because of a reduction of hours or (b) 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 FSA Benefits must 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 provide coverage that extends into a subsequent Plan Year).

Notwithstanding the foregoing, a Participant whose participation in the Plan terminates in 2020 may continue to receive reimbursements from any contributions that remain in his or her Health FSA as of the date of such termination through the end of the 2020 Plan Year and any related Grace Period.

7.9 Coordination of Benefits

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA will not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits will not be taken into account when determining benefits payable under any other plan.

ARTICLE VIII. DCAP Component

8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing (a) to receive benefits in the form of reimbursements for Dependent Care Expenses from the DCAP Component (DCAP Benefits), and (b) to pay his or her contribution for such DCAP Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Participant Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's portion of the DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000 annual benefit amount is elected, then the annual contribution amount is also $5,000.)

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term will not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual 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 (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) *Exclusion*. Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code Section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or

- a parent of a Participant's under age 13 qualifying child as defined in Code Section 152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available*. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment will be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage is $5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense and is either (1) physically or mentally incapable of self-care, or (2) a Student will be deemed to have Earned Income in the amount specified in Code Section 21(d)(2)); or
- either $5,000 or $2,500 for the calendar year, as applicable below:

  (1) The amount is $5,000 for the calendar year if one of the following applies: (a) the Participant is married and files a joint federal income tax return; (b) the Participant is married, files a separate federal income tax return, and meets the following conditions: (i) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (ii) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (iii) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or (c) the Participant is single or is the head of the household for federal income tax purposes.

  (2) The amounts is $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any

Period of Coverage is $0. (Note: The maximum annual benefit amount that a Participant may elect for the 2021 Plan year will not be affected by the Grace Period provided for in Section 8.4(c). A Participant may receive reimbursement during the Grace Period from any amount that remains in his or her 2020 DCAP Account as of December 31, 2020 and the amount elected by the Participant for the 2021 Plan Year. In addition, the maximum annual benefit amount that a Participant may elect for the 2021 Plan year will not be affected by any balance available to such Participant during the Grace Period provided for in Section 8.4(c). A Participant may receive reimbursement during the Grace Period from any amount that remains in his or her 2020 DCAP Account as of December 31, 2020 and the amount elected by the Participant for the 2021 Plan Year.)

(c) *Grace Period for 2020 Amounts; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(c), if an individual has amounts remaining in his or her DCAP Account as of December 31, 2020, such individual may be reimbursed for Dependent Care Expenses from such amount during the Grace Period from January 1, 2021 through December 31, 2021.

- Amounts remaining in a DCAP Account as of December 31, 2020 may not be cashed out or converted to any other taxable or non-taxable benefit.
- Dependent Care Expenses incurred during the Grace Period and approved for reimbursement in accordance will be reimbursed first from the 2020 DCAP Account amount and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the DCAP Account is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from 2020 DCAP Account amount if the card is unavailable for such reimbursement. An individual's 2020 DCAP Account amount will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such 2020 DCAP Account amount.
- For purposes of the Grace Period for amounts relating to the 2020 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2021 through December 31, 2021, must be submitted no later than April 30, 2022. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6.

(d) *Changes; No Proration*. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 10.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(e) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article X affecting annual contributions to the DCAP Component also will change

the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

8.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts*. A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*. A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance. All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred will be forfeited and applied as described above. Notwithstanding, the foregoing, including but not limited to the overall maximum provided in Section 8.4(b), in response to the continuing COVID-19 pandemic and in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, if a Participant has a balance in his or her DCAP Account as of December 31, 2020

and has a Qualifying Individual who attains the age of 13 either during the 2020 Plan Year, or during the 2021 Plan Year, such balance shall be carried over to the 2021 Plan Year. Such Participant may receive reimbursement for Dependent Care Expenses incurred during the 2021 Plan Year and submitted for reimbursement no later than March 31, 2022 from the balance carried over from the 2020 Plan Year for such Child that attained age 13 in the 2020 Plan Year or in the 2021 Plan Year only and not from any DCAP election for the 2021 Plan Year.

8.7 Reimbursement Claims Procedure for DCAP

(a) *Timing*. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Section 8.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application will be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a

Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25.

(c) *Claims Denied*. For reimbursement claims that are denied, see the appeals procedure in Article XI.

8.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible, with one exception: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred in the month that includes the date the Participant terminates employment or otherwise loses eligibility, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible. Notwithstanding the foregoing, a Participant whose participation in the Plan terminates in 2020 may continue to receive reimbursements from any amount that remains in his or her DCAP Account as of the date of such termination through the end of the 2020 Plan Year and any related Grace Period.

ARTICLE IX. HIPAA PROVISIONS FOR HEALTH FSA

9.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article IX:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer will have access to PHI from the Health FSA only as permitted under this Article IX or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the statutory provisions of which are incorporated herein by reference.

9.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

9.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

9.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 9.5 and obtaining written certification pursuant to Section 9.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

9.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer will:

- not use or further disclose the PHI other than as permitted or required by the Health FSA or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii) is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

9.6 Adequate Separation Between Plan and Employer

The Employer will allow the following persons access to PHI: Director of Finance, Accounting Manager, Senior Accountant, Accountant, the Plan Administrator, and payroll staff performing Health FSA functions and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons will have access to PHI. These specified employees (or classes of employees) will only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 9.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

9.7 Certification of Plan Sponsor

The Health FSA will disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Health FSA incorporates the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 9.5. Execution of the Plan by the Employer will serve as the required certification.

9.8 Privacy Official

The Employer will designate a Privacy Official, who will be responsible for the Plan's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys,

accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition and notwithstanding any provision of this Plan to the contrary, the Privacy Official will have the authority to and be responsible for:

- accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article;
- transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Employer;
- establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;
- establishing and overseeing proper training of personnel who will have access to PHI; and
- any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of the Article IX.

9.9 Interpretation and Limited Applicability

This Article serves the sole purpose of complying with the requirements of HIPAA and will be interpreted and construed in a manner to effectuate this purpose. Neither this Article IX nor the duties, powers, responsibilities, and obligations listed herein will be taken into account in determining the amount or nature of the benefits provided to any person covered under the Health FSA Component, nor will they inure to the benefit of any third parties. To the extent that any of the provisions of this Article IX are no longer required by HIPAA or do not apply to the Plan because the Plan is otherwise excepted from HIPAA, they will be deemed deleted and will have no force or effect.

9.10 Service Performed for the Employer

Notwithstanding any other provisions of this Plan to the contrary, all services performed by a business associate for the Health FSA in accordance with the applicable service agreement will be deemed to be performed on behalf of the Health FSA and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. Parts 160 through 164, except services that relate to eligibility and enrollment in the Health FSA. If a business associate of the Health FSA performs any services that relate to eligibility and enrollment in the Health FSA, these services will be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Health FSA.

ARTICLE X. Irrevocability of Elections; Exceptions

10.1 Irrevocability of Elections

Except as described in this Article X, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Plan Options.

10.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election*. A Participant (or an Eligible Employee who, when first eligible under Section 4.2 or during the Open Enrollment Period under Section 4.3, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 10.3 (or within 60 days of the occurrence of an event described in Section 10.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Insurance Plans will automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 10.2 will be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 10.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes will be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Plan Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 8.4 respectively.

10.3 Events Permitting Exception to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) *Open Enrollment Period (Applies to all Benefit Plan Options)*. A Participant may change an election during the Open Enrollment Period in accordance with Section 4.3.

(b) *Termination of Employment (Applies to all Benefit Plan Options).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Section 3.3.

(c) *Leaves of Absence (Applies to all Benefit Plan Options).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.5 and upon non-FMLA leave in accordance with Section 3.6.

(d) *Change in Status (Applies to Premium Payment ~~Benefit,s~~Benefits and to Health FSA Benefits and DCAP Benefits as limited further below).* A Participant may change his or her election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that

affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits under Medical Insurance Plans only, and not to any other Insurance Plan, Health FSA, or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (a) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (b) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child will be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of Section 10.3(e)(1), a loss of eligibility includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit Plan is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit

on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders* (*Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits)*. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a National Medical Support Order) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 10.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (a) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (b) an HMO and a PPO are considered to be similar coverage; and (c) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Plan Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Plan Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Plan Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Plan Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Plan Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Plan Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Plan Option that has decreased in cost; or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Plan Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Plan Option. 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.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 10.3(h)(1) through 10.3(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) and 152(f)(4).

(i) Change in Coverage (*Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits*).

The definition of "similar coverage" under Section 10.3(h) applies also to this Section 10.3(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Plan Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Plan Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit

under an accident or health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Plan Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA) or drop coverage if no other Benefit Plan Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 10.3(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Plan Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Plan Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Plan Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(d) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (i) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (ii) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) *Addition or Significant Improvement of a Benefit Plan Option.* If during a Period of Coverage the Plan adds a new Benefit Plan Option or significantly improves an existing Benefit Plan Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Plan Option other than the newly added or significantly improved Benefit Plan Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Plan Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Plan Option on a prospective basis, subject to the terms

and limitations of the Benefit Plan Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Plan Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Plan Option(s).

(4) *Change in Coverage Under An Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(~~1~~5) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to

satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan), then the Participant may increase his or her election to pay for such coverage.

(~~2~~6) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(~~3~~7) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

A Participant entitled to change an election as described in this Section 10.3 must do so in accordance with the procedures described in Section 10.2.

10.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XI. Appeals Procedure

11.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims will be administered in accordance with the claims procedure set forth in Appendix C of this Plan.

11.2 Claims Procedures for Insurance Benefits

Claims and reimbursement for benefits under any Insurance Plan will be administered in accordance with the claims procedures for the Insurance Plans, as set forth in their governing plan documents and/or summary plan descriptions.

ARTICLE XII. Recordkeeping and Administration

12.1 Plan Administrator

The administration of this Plan will be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 Powers of the Plan Administrator

The Plan Administrator will have such duties and powers as it considers necessary or appropriate to discharge its duties. It will have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator will have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan will remain the obligation of the Plan Administrator or the Employer, as applicable.

12.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator will not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties will be paid by the Employer.

12.7 Insurance Contracts

The Employer will have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited following a reasonable time after the date any such payment first became due.

12.9 Effect of Mistake

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

ARTICLE XIII. General Provisions

13.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer.

13.2 No Contract of Employment

Nothing herein contained is intended to be or will be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

13.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action.

13.4 Governing Law

The provisions of the Plan will be construed, administered and enforced according to applicable federal law and, to the extent not preempted, the laws of the State of California.

13.5 Compliance With Code and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

13.6 No Guarantee of Tax Consequences

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

13.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant will indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security or Medicare taxes, or other taxes from such payments or reimbursements.

13.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

13.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan will be controlling.

13.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan will be given effect to the maximum extent possible.

* * *

To record the adoption of the Plan, the Employer's authorized representative hereby executes this document on this _____ day of _____, ~~2012~~2021.

Alameda County Transportation Commission

By: _____

Title: _____

Date: _____

Appendix A

Benefit Plan Options

Benefit Plan Options will include the coverage available under the following plans maintained by the Alameda County Transportation Commission:

A. Insurance Plans

1. Medical Insurance under the Public Employees' Medical and Hospital Care Act (PEMHCA or "PERS Health")
2. Dental Insurance
3. Vision Insurance
4. Long-Term Disability Insurance
5. Short-Term Disability Insurance
6. Group-Term Life Insurance (on the life of an Employee only)

B. Health Care Flexible Spending Account

C. Dependent Care Flexible Spending Account

Appendix B

Exclusions: Medical Expenses that are Not Reimbursable from the Health FSA

The Alameda County Transportation Commission Cafeteria Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs. Such "medical care" also includes expenses incurred for menstrual care products. A 'menstrual care product' means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under legal requirements applicable to health FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer)
- Long-term care services
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework)
- Custodial care

~~Medicines or drugs (other than insulin) that have not been prescribed~~

- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement)
- Bottled water
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Transportation expenses of any kind, including transportation expenses to receive medical care
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Any item that does not constitute "medical care" as defined under Code Section 213(d)
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. Section 1.125-5(k)(4) or other applicable law or regulations

Appendix C

Claims Procedures

Capitalized terms in this Appendix C have the same meaning as the defined terms in the Alameda County Transportation Commission Cafeteria Plan.

Any Participant may file a claim with the Plan Administrator for a Plan benefit to which the claimant believes that he or she is entitled.

1. The Plan Administrator will receive all claims filed for benefits under the Plan. Upon receiving a claim, the Plan Administrator will review the claim and determine whether the claimant is entitled to receive any benefits pursuant to such claim. The Plan Administrator will notify the claimant in writing of any adverse decision with respect to his or her claim within 30 days after its submission. The notice of any adverse decision will be written in a manner calculated to be understood by the claimant and must include, as applicable: (i) the specific reason or reasons for the denial; (ii) specific references to the Plan provisions on which the denial is based; (iii) 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 (iv) an explanation of the Plan's claim review procedures.

2. If the circumstances require an extension of time for processing the initial claim, a written notice of the extension will be furnished to the claimant before the end of the initial 30-day period. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The extension notice must indicate the circumstances requiring an extension of time.

3. If a claim for benefits is denied or if the Plan Administrator has given no response to such claim within the time period set out in the above paragraph (in which case the claim for benefits will be deemed to be denied), the claimant or his or her duly authorized representative, at the claimant's sole expense, may appeal the denial by submitting written notice of such appeal to the Plan Administrator within 90 days of the receipt of written notice of the denial or 60 days from the date such claim is deemed to be denied.

4. The claimant will be notified of the decision on the appeal within 90 days of receipt of the notice of appeal, unless circumstances require an extension of time for processing, in which case a decision will be rendered as soon as possible, but not later than 120 days after receipt of a notice of appeal. If such an extension of time is required, written notice of the extension will be furnished to the claimant before the end of the original 90-day period. The notice of decision on the appeal must be made in writing. If the decision on the appeal is not furnished within the time specified above, the appeal of the claim will be deemed denied.

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ALAMEDA COUNTY TRANSPORTATION COMMISSION
CAFETERIA PLAN

As Restated Effective January 1, ~~2020~~2021

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ALAMEDA COUNTY TRANSPORTATION COMMISSION
CAFETERIA PLAN

As ~~Restated~~Adopted Effective January 1, ~~2020~~2021

ARTICLE I. Introduction

1.1 Establishment of Plan

Alameda County Transportation Commission (the Employer) hereby restates Alameda County Transportation Commission Cafeteria Plan (the Plan) effective January 1, ~~2020~~2021 (the Effective Date) to incorporate ~~applicable~~ COVID-19 related relief in accordance with the Consolidated Appropriations Act, 2021~~ and~~, IRS Notice 2021-15~~.~~ and the American Rescue Plan of 2021. The Plan was established effective as of February 1, 2012 and was last restated effective January 1, 2020. Capitalized terms used in this Plan that are not otherwise defined have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of contributions for the Benefit Plan Options in Appendix A on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an Employee's account for reimbursement of certain Medical Care Expenses (Health FSA Account) and/or to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan under Code Section 125 and will be interpreted and administered consistent with the requirements of Code Section 125 and the regulations issued thereunder.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code Section 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b). The DCAP Component is intended to qualify as a dependent care assistance program under Code Section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of HIPAA and COBRA. In the event that the Health FSA Component is determined not to be a separate plan, the Plan will be designated as a hybrid entity for purposes of HIPAA, such that it will be a covered entity only with respect to the Health FSA Component.

ARTICLE II. Definitions

2.1 Definitions

Account(s) means the Health FSA Accounts and the DCAP Accounts described in Sections 7.5 and 8.5.

Benefit Plan Option means a qualified benefit under Code Section 125(f) that is available to a Participant under this Plan as set forth in Appendix A, as amended from time to time. The Employer may substitute, add, subtract, or revise at any time the menu of such Benefit Plan Options and/or the benefits, terms, and conditions of any such options or plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Board of Directors means the Board of Commissioners of the Alameda County Transportation Commission.

Change in Status means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986 and the Treasury Regulations issued thereunder, as amended.

Compensation means the cash wages or salary paid to an Employee by the Employer.

DCAP means dependent care assistance program.

DCAP Account means the account described in Section 8.5.

DCAP Benefits has the meaning described in Section 8.1.

DCAP Component means the component of this Plan described in Article VIII.

Dependent means: (a) for purposes of accident or health coverage, (1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code Section 152(f)(1) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any National Medical Support Order, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 8.3.

Earned Income will have the meaning given such term in Code Section 129(e)(2).

Effective Date of this Plan means January 1, ~~2020~~2021.

Election Form/Salary Reduction Agreement means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Benefit Plan Options(s) and authorizing Salary Reductions to pay for any of the Benefit Plan Options.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Section 3.1.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; and (c) any employee covered under a collective bargaining agreement, unless that agreement provides for the employee's participation in the Plan. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for a limited duration following termination of employment

provided any required contributions are made and only to the extent specifically provided under this Plan.

Employer means the Alameda County Transportation Commission.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Grace Period means 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. Notwithstanding the foregoing, for purposes of the Plan Year ending December 31, ~~2020~~2021, the Grace Period is the period from January 1, ~~2021~~2022 through December 31, ~~2021~~2022. (Note: For purposes of the DCAP, ~~as the Grace Period is available pursuant to the relief provided in the Consolidated Appropriations Act, 2021,~~ the Grace Period is available for amounts in DCAP Accounts that remain as of December 31, ~~2020~~2021 only. The Grace Period is available under the Health FSA irrespective of the relief.)

Health FSA means the health flexible spending arrangement.

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Plan(s) means the plan(s) that the Employer maintains for its Employees (and for their Spouses, same-sex spouses, domestic partners, and Dependents that may be eligible under the terms of such plan), which provide benefits through a group insurance policy or policies (e.g., medical, dental and vision insurance). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Medical Care Expenses has the meaning described in Section 7.3.

Nonelective Contribution(s) means any amount that the Employer, in its sole discretion, may contribute under the Plan to provide benefits for individual Participants and their Spouses, Dependents, domestic partners, and same-sex spouses, as applicable, under one or more of the Benefit Plan Options offered under the Plan.

Open Enrollment Period means the period during the Plan Year during which Eligible Employees may elect to participate in the Plan or make changes to their elections for the next Plan Year. The Employer will determine this period each Plan Year, which the Plan Administrator will make known in the Plan's open enrollment materials.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include those who elect one or more Benefit Plan Options under the Plan.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date on which participation commences, as described in Section 4.2; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.3.

Plan means the Alameda County Transportation Commission Cafeteria Plan as set forth herein, as amended from time to time.

Plan Administrator means the person(s), entity, or committee as may be appointed from time to time by the Board of Directors (or its authorized designee) to administer the Plan. If no such person, entity, or committee is appointed, the Plan Administrator is the Employer.

Plan Sponsor means the Employer.

Plan Year means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year will be the entire short plan year.

Premium Payment Benefits means the Premium Payment Benefits described in Section 6.1.

Premium Payment Component means the component of this Plan described in Article VI.

Qualifying Dependent Care Services has the meaning described in Section 8.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1); (b) a tax dependent of the Participant as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child will, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and will not be treated as a Qualifying Individual with respect to the noncustodial parent. Furthermore, notwithstanding the foregoing, in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15 and subject to Section 8.~~6,~~4 for purposes of the ~~2020~~2021 Plan Year, the term "Qualifying Individual" shall also include a tax dependent of the Participant as defined in Code Section 152(a)(1) who attains the age of thirteen (13) at any time during the ~~2020~~2021 calendar year, who has the same principal place of abode as the Participant for more than one-half of the Plan Year, and who has not provided over one-half of his or her own support for the Plan Year.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. A domestic partner or same-sex spouse is not treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCAP Component the term Spouse does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

All full-time Employees are eligible to participate in the Plan. To become a Participant, an Eligible Employee must make a timely election to participate in accordance with Article IV. Eligibility for any Benefit Plan Option will be subject to the requirements specified in the governing plan documents of the applicable Benefit Plan Option. The provisions of this Article are not intended to override any eligibility requirement or waiting period specified in the applicable Benefit Plan Options and the terms of eligibility and participation for any Benefit Plan Option offered under the Plan are subject to the requirements specified in the Benefit Plan Option's governing documents.

3.2 Use of Contributions

As a Participant, an Employee will be permitted to (1) elect Benefit Plan Options for which he or she is eligible, (2) receive available Nonelective Contributions for which he or she is eligible in the manner set forth in the enrollment materials, (3) pay his or her share of the cost of his or her elected benefits with Salary Reduction contributions, and (4) if permitted under the terms of the Benefit Plan Options and uniform rules adopted by the Plan Administrator, pay his or her share of the costs of the elected benefits with after-tax dollars (e.g., if Salary Reduction contributions are not available or are insufficient to pay his or her share of the cost of the Benefit Plan Option). In addition, as a Participant, an Employee may be permitted to elect health coverage for an individual who is not the employee’s Spouse or Dependent if permitted under the terms of the Benefit Plan Options and in accordance with uniform rules adopted by the Plan Administrator; provided, however, that the fair market value of such coverage will be included in the Employee’s gross income to the extent required by applicable law, and the Employee will be treated as having purchased the coverage with after-tax dollars.

3.3 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the date the Participant makes a permitted election not to participate in the Plan;

(b) the date that the Participant no longer satisfies the eligibility requirements of this Plan or all of the Benefit Plan Options. Notwithstanding the foregoing, for purposes of pre-tax COBRA coverage, certain Employees may continue eligibility for certain periods subject to the restrictions and terms otherwise described in this Plan; or

(c) The date that the Plan is either terminated or amended to exclude the Participant or the class of employees to which the Participant belongs.

Termination of participation in this Plan will automatically revoke the Participant's elections. Benefits under any Insurance Plan will terminate as of the date(s) specified in the Insurance Plan. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for DCAP Benefits. If revocation occurs under this Section 3.3, no new election may be made by such Participant during the remainder of the Plan Year except as set forth in Section 3.4.

3.4 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, or otherwise loses eligibility and then is rehired or becomes eligible once again within 30 days or less after the date of a termination of employment or loss of eligibility, then the Employee will be reinstated with the same elections that such individual had before termination or other loss of eligibility. If a former Participant is rehired more than 30 days following termination of employment or becomes eligible after 30 days following a loss of eligibility and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 4.2. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the applicable Insurance Plan is reinstated.

3.5 FMLA Leaves of Absence

(a) *Health Insurance Benefits*. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health insurance benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the contributions for those benefits under this Plan.

An Employer may require participants to continue all health insurance benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the contributions will be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her health insurance benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage

while on FMLA leave, then the Participant may pay his or her share of the contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue health insurance benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's health insurance benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Premium Payment Component or Health FSA Component as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health insurance benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits, a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such benefits when the Participant is on non-FMLA leave, as described in Section 3.6. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be

required to repay the contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.6 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the applicable election change rules in Section 10.3 will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Election to Participate

To become a Participant, an Eligible Employee must submit a completed and signed Election Form/Salary Reduction Agreement to the Plan Administrator in the time and in the manner required by the Plan Administrator.

4.2 Elections When First Eligible

(a) *Currently Eligible Employees*. An Employee who is eligible to participate in this Plan as of the Effective Date must complete, sign, and file an Election Form/Salary Reduction Agreement with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan to become a Participant on the Effective Date. The elections made by the Eligible Employee on this initial Election Form/Salary Reduction Agreement will be effective for the Plan Year beginning on the Effective Date.

(b) *New Employees or Newly Eligible Employees*. An Employee who first becomes eligible to participate in the Plan mid-year (and after the Effective Date) may elect to commence participation in the Plan after the eligibility requirements of Section 3.1 have been satisfied by completing, signing, and filing an Election Form/Salary Reduction Agreement with the Plan Administrator in the time and in the manner required by the Plan Administrator. Participation in the Plan will commence on the first day of the month following the Plan Administrator's receipt of a properly completed and signed Election Form/Salary Reduction Agreement. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 10.3. Eligibility for Premium Payment Benefits will be subject to the additional requirements, if any, specified in the applicable Insurance Plans.

4.3 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator will provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement will enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it will become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 10.3.

4.4 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.2 and 4.3, then the Employee may not elect any benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 10.3. Notwithstanding any contrary provision in the Plan, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for benefits under an Insurance Plan and has made an effective election for such benefits outside the Plan, then the Employee's share of the contributions for such benefits will automatically be paid with pre-tax dollars and will be deemed a "default election" under the Plan. Such default elections cannot be changed until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 10.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. No default elections are permitted for Health FSA or DCAP Benefits.

4.5 Irrevocability of Elections

Unless an exception applies (as described in Article X), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following benefits:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII.

(c) DCAP Benefits, as described in Article VIII.

In no event will benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article VII. No Grace Period is available for DCAP Benefits.

5.2 Source of Benefit Funding

The cost of coverage under the component Benefit Plan Options will be funded by a Participant's Salary Reductions, Nonelective Contributions provided by the Employer, or a combination of the foregoing. The required contributions for each of the Benefit Plan Options offered under the Plan will be made known to employees in annual enrollment materials. Salary Reduction Contributions that are allocated to any Benefit Plan Option will equal the contributions required from the Participant less any available Nonelective Contributions allocated to that option. A Participant may elect to receive Nonelective Contributions in the form of cash to the extent described in the applicable annual enrollment materials. The maximum amount of employee contributions, plus any Nonelective Contributions made available by the Employer, will not exceed the aggregate cost of the Benefit Plan Options elected.

5.3 Employer Contributions

The Employer may, in its sole discretion, make Nonelective Contributions on behalf of a Participant toward the cost of one or more Benefit Plan Options. The amount of Nonelective Contributions that may be applied towards the cost of each of the Benefit Plan Option(s) for any Participant will be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the Employer's sole discretion. The amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer may prescribe.

No provision of this Plan will be construed to require the Employer or Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made. The Plan does not create a trust in favor of a Participant or any person claiming on a Participant’s behalf.

ARTICLE VI. Premium Payment Component

6.1 Benefits

An Eligible Employee can elect to participate in the Premium Payment Component by electing (a) to receive benefits under the Insurance Plans described in Appendix A; and (b) to pay for his or her share of the contributions for those benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision in this Plan, insurance benefits under the Insurance Plans are subject to the terms and conditions of the Insurance Plans, and no changes can be made with respect to such plans (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan.

6.2 Participant Contributions for Cost of Coverage

The annual contribution for a Participant's portion of the Premium Payment Benefits is equal to the amount as set by the Employer in the annual enrollment materials.

6.3 Benefits Provided Under the Insurance Plans

Insurance benefits will be provided by the Insurance Plans in accordance with their governing documents, and not this Plan. The types and amounts of insurance benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of such plans are set forth in their governing documents. All claims to receive benefits under the Insurance Plans will be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance with those plans, as may be amended from time to time.

6.4 Insurance Benefits; COBRA

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 health coverage terminates under an Insurance Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), will be given the opportunity to continue on a self-pay basis the same health coverage that he or she had under the applicable Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage will be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage under an Insurance Plan 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 (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) 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 Insurance Plan benefits will be paid on an after-tax basis (unless as may be otherwise 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).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay his or her contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Participant Contributions for Cost of Coverage of Health FSA Benefits

The annual contribution for a Participant's portion of the Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in the annual enrollment materials.

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force. In addition,

certain individuals may receive reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 7.4(e).

(a) *Incurred*. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses*. "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or
- any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

7.4 Maximum and Minimum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage*. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 or is entitled to submit expenses incurred during a Grace Period as provided in Section 7.4(e). Payment will be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or during a Grace Period, if applicable under Section 7.4(e)), provided that the other requirements of this Article VII have been satisfied. Notwithstanding the foregoing, in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, a Participant whose participation in the Plan terminates in ~~2020~~2021 may continue to receive reimbursements from any contributions that remain in his or her Health FSA as of the date of such termination through the end of ~~the 2020~~2021 Plan Year, including any Grace Period.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage will be set forth in the enrollment materials~~,~~ but shall be no more than the contribution limit announced by the IRS for the applicable year. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage is $0. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents will be charged against the Participant's Health FSA Account. Unless otherwise permitted under applicable law, the maximum annual benefit may not exceed the maximum limit provided under such law.

(c) *Changes; No Proration.* For each Plan Year, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 10.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article X (other than under Section 10.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 10.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 7.4(e), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts") if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card

(e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.

- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the April 30 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. For purposes of the Grace Period: (i) for amounts relating to the 2020 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2021 through December 31, 2021, must be submitted no later than April 30, 2022.; and (ii) for purposes of amounts relating to the 2021 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2022 through December 31, 2022, must be submitted no later than April 30, 2023. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 7.4(e)).

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement will in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule

(a) *Use-or-Lose Rule*. Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance.

(b) *Use of Forfeitures.* All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred will be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing*. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical

condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Participant's Health FSA Account for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied*. For reimbursement claims that are denied, see the appeals procedure in Article XI.

(d) *Claims Ordering; No Reprocessing*. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which 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 Medical Care Expenses incurred during the Period of Coverage 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 7.4(e)), 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.

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 FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance 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 in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage will be subject to all conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of a Plan

Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year in accordance with the provisions of Section 7.4(e).

Contributions for coverage for Health FSA Benefits 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 (a) because the Employee ceases to be eligible because of a reduction of hours or (b) 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 FSA Benefits must 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 provide coverage that extends into a subsequent Plan Year).

Notwithstanding the foregoing, a Participant whose participation in the Plan terminates in ~~2020~~2021 may continue to receive reimbursements from any contributions that remain in his or her Health FSA as of the date of such termination through the end of the ~~2020~~2021 Plan Year ~~and~~, including any ~~related~~ Grace Period.

7.9 Coordination of Benefits

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA will not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits will not be taken into account when determining benefits payable under any other plan.

ARTICLE VIII. DCAP Component

8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing (a) to receive benefits in the form of reimbursements for Dependent Care Expenses from the DCAP Component (DCAP Benefits), and (b) to pay his or her contribution for such DCAP Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Participant Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's portion of the DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000 annual benefit amount is elected, then the annual contribution amount is also $5,000.)

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term will not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual 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 (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) *Exclusion*. Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code Section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child as defined in Code Section 152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available*. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) and any balance covered by a Grace Period will only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount

that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment will be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage is $5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense and is either (1) physically or mentally incapable of self-care, or (2) a Student will be deemed to have Earned Income in the amount specified in Code Section 21(d)(2)); or
- either $5,000 or $2,500 for the calendar year, as applicable below:

  (1) The amount is $5,000 for the calendar year if one of the following applies: (a) the Participant is married and files a joint federal income tax return; (b) the Participant is married, files a separate federal income tax return, and meets the following conditions: (i) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (ii) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (iii) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or (c) the Participant is single or is the head of the household for federal income tax purposes.

  (2) The amounts is $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage is $0. (Note: The maximum annual benefit amount that a Participant may elect for the 2021 Plan year will not be affected by the Grace Period provided for in Section 8.4(c). A Participant may receive reimbursement during the Grace Period from any amount that remains in his or her 2020 DCAP Account as of December 31, 2020 and the amount elected by the Participant for the 2021 Plan Year. In addition, the maximum annual benefit amount that a Participant may elect for the ~~2021~~2022 Plan year will not be affected by ~~any balance available to such Participant during~~ the Grace Period provided for in Section 8.4(c). A Participant may receive reimbursement during the Grace Period from any amount that remains in his or her ~~2020~~2021 DCAP Account as of December 31, ~~2020~~2021 and the amount elected by the Participant for the ~~2021~~2022 Plan Year.)

(c) *Grace Period for 2020 Amounts; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(c), if an individual has amounts remaining in his or her DCAP Account as of December 31, 2020, such individual may be reimbursed for Dependent Care Expenses from such amount during the Grace Period from January 1, 2021 through December 31, 2021.

- Amounts remaining in a DCAP Account as of December 31, 2020 may not be cashed out or converted to any other taxable or non-taxable benefit.
- Dependent Care Expenses incurred during the Grace Period and approved for reimbursement in accordance will be reimbursed first from the 2020 DCAP Account amount and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the DCAP Account is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from 2020 DCAP Account amount if the card is unavailable for such reimbursement. An individual's 2020 DCAP Account amount will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such 2020 DCAP Account amount.
- For purposes of the Grace Period for amounts relating to the 2020 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2021 through December 31, 2021, must be submitted no later than April 30, 2022. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6.

(d) *Grace Period for 2021 Amounts; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(d), if an individual has amounts remaining in his or her DCAP Account as of December 31, 2021, such individual may be reimbursed for Dependent Care Expenses from such amount during the Grace Period from January 1, 2022 through December 31, 2022.

- Amounts remaining in a DCAP Account as of December 31, 2021 may not be cashed out or converted to any other taxable or non-taxable benefit.
- Dependent Care Expenses incurred during the Grace Period and approved for reimbursement in accordance will be reimbursed first from the 2021 DCAP Account amount and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the DCAP Account is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from 2021 DCAP Account amount if the card is unavailable for such reimbursement. An individual's 2021 DCAP Account amount will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such 2021 DCAP Account amount.

- For purposes of the Grace Period for amounts relating to the 2021 Plan Year, claims for reimbursement incurred during the Grace Period from January 1, 2022 through December 31, 2022, must be submitted no later than April 30, 2023. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6.

(e) *Changes; No Proration*. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 10.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(f) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article X affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

8.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts*. A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*. A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance. All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred will be forfeited and applied as described above. Notwithstanding, the foregoing, including but not limited to the overall maximum provided in Section 8.4(b), in response to the continuing COVID-19 pandemic and in accordance with the Consolidated Appropriations Act, 2021 and IRS Notice 2021-15, if a Participant has a balance in his or her DCAP Account as of December 31, 2020 and has a Qualifying Individual who attains the age of 13 either during the 2020 Plan Year, or during the 2021 Plan Year, such balance shall be carried over to the 2021 Plan Year. Such Participant may receive reimbursement for Dependent Care Expenses incurred during the 2021 Plan Year and submitted for reimbursement no later than March 31, 2022 from the balance carried over from the 2020 Plan Year for such Child that attained age 13 in the 2020 Plan Year or in the 2021 Plan Year only and not from any DCAP election for the 2021 Plan Year.

8.7 Reimbursement Claims Procedure for DCAP

(a) *Timing*. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Section 8.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;

- the name of the person, organization or entity to whom the expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application will be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25.

(c) *Claims Denied*. For reimbursement claims that are denied, see the appeals procedure in Article XI.

8.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible, with one exception: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred in the month that includes the date the Participant terminates employment or otherwise loses eligibility, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible. Notwithstanding the foregoing, a Participant whose participation in the Plan terminates in ~~2020~~2021 may continue to receive reimbursements from any amount that remains in his or her DCAP Account as of the date of such termination through the end of the ~~2020~~2021 Plan Year~~ and any related Grace Period~~.

ARTICLE IX. HIPAA PROVISIONS FOR HEALTH FSA

9.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article IX:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer will have access to PHI from the Health FSA only as permitted under this Article IX or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the statutory provisions of which are incorporated herein by reference.

9.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

9.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

9.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 9.5 and obtaining written certification pursuant to Section 9.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

9.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer will:

- not use or further disclose the PHI other than as permitted or required by the Health FSA or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the “firewall”), required in 45 CFR Section 504(f)(2)(iii) is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

9.6 Adequate Separation Between Plan and Employer

The Employer will allow the following persons access to PHI: Director of Finance, Accounting Manager, Senior Accountant, Accountant, the Plan Administrator, and payroll staff performing Health FSA functions and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons will have access to PHI. These specified employees (or classes of employees) will only have access to and use PHI to the extent necessary to perform the plan administration functions that

the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 9.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

9.7 Certification of Plan Sponsor

The Health FSA will disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Health FSA incorporates the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 9.5. Execution of the Plan by the Employer will serve as the required certification.

9.8 Privacy Official

The Employer will designate a Privacy Official, who will be responsible for the Plan's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition and notwithstanding any provision of this Plan to the contrary, the Privacy Official will have the authority to and be responsible for:

- accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article;
- transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Employer;
- establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;
- establishing and overseeing proper training of personnel who will have access to PHI; and
- any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of the Article IX.

9.9 Interpretation and Limited Applicability

This Article serves the sole purpose of complying with the requirements of HIPAA and will be interpreted and construed in a manner to effectuate this purpose. Neither this Article IX nor the duties, powers, responsibilities, and obligations listed herein will be taken into account in determining the amount or nature of the benefits provided to any person covered under the Health FSA Component, nor will they inure to the benefit of any third parties. To the extent that any of the provisions of this Article IX are no longer required by HIPAA or do not apply to the Plan because the Plan is otherwise excepted from HIPAA, they will be deemed deleted and will have no force or effect.

9.10 Service Performed for the Employer

Notwithstanding any other provisions of this Plan to the contrary, all services performed by a business associate for the Health FSA in accordance with the applicable service agreement will be deemed to be performed on behalf of the Health FSA and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. Parts 160 through 164, except services that relate to eligibility and enrollment in the Health FSA. If a business associate of the Health FSA performs any services that relate to eligibility and enrollment in the Health FSA, these services will be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Health FSA.

ARTICLE X. Irrevocability of Elections; Exceptions

10.1 Irrevocability of Elections

Except as described in this Article X, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Plan Options.

10.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election*. A Participant (or an Eligible Employee who, when first eligible under Section 4.2 or during the Open Enrollment Period under Section 4.3, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 10.3 (or within 60 days of the occurrence of an event described in Section 10.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Insurance Plans will automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 10.2 will be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 10.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes will be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Plan Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 8.4 respectively.

10.3 Events Permitting Exception to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) *Open Enrollment Period (Applies to all Benefit Plan Options)*. A Participant may change an election during the Open Enrollment Period in accordance with Section 4.3.

(b) *Termination of Employment (Applies to all Benefit Plan Options).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Section 3.3.

(c) *Leaves of Absence (Applies to all Benefit Plan Options).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.5 and upon non-FMLA leave in accordance with Section 3.6.

(d) *Change in Status (Applies to Premium Payment Benefits and to Health FSA Benefits and DCAP Benefits as limited further below).* A Participant may change his or her election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits under Medical Insurance Plans only, and not to any other Insurance Plan, Health FSA, or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (a) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (b) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant’s or Dependent’s coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child will be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of Section 10.3(e)(1), a loss of eligibility includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit Plan is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders* (*Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits)*. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a National Medical Support Order) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 10.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (a) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (b) an HMO and a PPO are considered to be similar coverage; and (c) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Plan Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Plan Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Plan Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Plan Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Plan Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Plan Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Plan Option that has decreased in cost; or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Plan Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Plan Option. 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.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 10.3(h)(1) through 10.3(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) and 152(f)(4).

(i) Change in Coverage (*Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits*).

The definition of "similar coverage" under Section 10.3(h) applies also to this Section 10.3(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Plan Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Plan Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Plan Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Health FSA) or drop coverage if no other Benefit Plan Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 10.3(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Plan Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Plan Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Plan Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(d) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (i) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (ii) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) *Addition or Significant Improvement of a Benefit Plan Option.* If during a Period of Coverage the Plan adds a new Benefit Plan Option or significantly improves an existing Benefit Plan Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Plan Option other than the newly added or significantly improved Benefit Plan Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Plan Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Plan Option on a prospective basis, subject to the terms and limitations of the Benefit Plan Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Plan Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Plan Option(s).

(4) *Change in Coverage Under An Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(5) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan), then the Participant may increase his or her election to pay for such coverage.

(6) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(7) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

(j) Mid-Year Election Changes Permitted by Consolidated Appropriations Act, 2021

Notwithstanding anything in the Plan to the contrary, subject to and in accordance with the Consolidated Appropriations Act, 2021 and any guidance implementing thereto, including but not limited to IRS Notice 2021-15, the following mid-year election plan changes are permissible:

- During the period from June 1, 2021 through August 31, 2021, Participants may, on a prospective basis, request to revoke, increase or decrease their 2021 Plan Year Salary Reduction amount or make a new election under the applicable Health FSA. A Participant may change his or her election pursuant to this provision not more than three (3) times during the period from June 1, 2021 through August 31, 2021;
    - Any election to decrease a Health FSA election will be limited to amount already reimbursed to or contributed by the Participant, whichever is greater;
- During the period from June 1, 2021 through August 31, 2021, Participants may, on a prospective basis, request to revoke, increase or decrease their 2021 Plan Year Salary Reduction amount under the DCAP Account;
    - For purposes of this Section 10.3(i), the $5,000 and $2,500 maximums provided in Section 8.4(b) are replaced with $10,500 and $5,250, respectively;
    - Any election to decrease a DCAP Account election will be limited to the amount already reimbursed to or contributed by the Participant, whichever is greater;
- The above referenced changes shall be effective as of the first payroll period after the required submission date that follows the Plan Administrator's receipt of a proper election change request, and if a Participant requests to reduce his or her Health FSA election to the amount of reimbursements received or the amount already contributed, Salary Reductions for the remainder of the Plan Year will be adjusted accordingly. Notwithstanding the foregoing, while Salary Reduction amounts are applied prospectively under any revised election, amounts contributed to the Health FSA and/or DCAP Account after the revised election may be used to reimburse any Medical Care Expense or Dependent Care Expenses, as applicable, incurred on or after January 1, 2021 or through the end of the 2021 Plan Year, subject to any Grace Period.

A Participant entitled to change an election as described in this Section 10.3 must do so in accordance with the procedures described in Section 10.2.

10.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XI. Appeals Procedure

11.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims will be administered in accordance with the claims procedure set forth in Appendix C of this Plan.

11.2 Claims Procedures for Insurance Benefits

Claims and reimbursement for benefits under any Insurance Plan will be administered in accordance with the claims procedures for the Insurance Plans, as set forth in their governing plan documents and/or summary plan descriptions.

ARTICLE XII. Recordkeeping and Administration

12.1 Plan Administrator

The administration of this Plan will be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 Powers of the Plan Administrator

The Plan Administrator will have such duties and powers as it considers necessary or appropriate to discharge its duties. It will have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator will have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan will remain the obligation of the Plan Administrator or the Employer, as applicable.

12.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator will not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties will be paid by the Employer.

12.7 Insurance Contracts

The Employer will have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of

such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited following a reasonable time after the date any such payment first became due.

12.9 Effect of Mistake

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

ARTICLE XIII. General Provisions

13.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer.

13.2 No Contract of Employment

Nothing herein contained is intended to be or will be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

13.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action.

13.4 Governing Law

The provisions of the Plan will be construed, administered and enforced according to applicable federal law and, to the extent not preempted, the laws of the State of California.

13.5 Compliance With Code and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the

provisions of the Code will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

13.6 No Guarantee of Tax Consequences

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

13.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant will indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security or Medicare taxes, or other taxes from such payments or reimbursements.

13.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

13.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan will be controlling.

13.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan will be given effect to the maximum extent possible.

* * *

To record the adoption of the Plan, the Employer's authorized representative hereby executes this document on this _____ day of _____, 2021.

Alameda County Transportation Commission

By: _____

Title: _____

Date: _____

Appendix A

Benefit Plan Options

Benefit Plan Options will include the coverage available under the following plans maintained by the Alameda County Transportation Commission:

A. Insurance Plans

1. Medical Insurance under the Public Employees' Medical and Hospital Care Act (PEMHCA or "PERS Health")
2. Dental Insurance
3. Vision Insurance
4. Long-Term Disability Insurance
5. Short-Term Disability Insurance
6. Group-Term Life Insurance (on the life of an Employee only)

B. Health Care Flexible Spending Account

C. Dependent Care Flexible Spending Account

Appendix B

Exclusions: Medical Expenses that are Not Reimbursable from the Health FSA

The Alameda County Transportation Commission Cafeteria Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs. Such "medical care" also includes expenses incurred for menstrual care products. A 'menstrual care product' means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under legal requirements applicable to health FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer)
- Long-term care services
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework)
- Custodial care
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement)
- Bottled water
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Transportation expenses of any kind, including transportation expenses to receive medical care
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Any item that does not constitute "medical care" as defined under Code Section 213(d)
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. Section 1.125-5(k)(4) or other applicable law or regulations

Appendix C

Claims Procedures

Capitalized terms in this Appendix C have the same meaning as the defined terms in the Alameda County Transportation Commission Cafeteria Plan.

Any Participant may file a claim with the Plan Administrator for a Plan benefit to which the claimant believes that he or she is entitled.

1. The Plan Administrator will receive all claims filed for benefits under the Plan. Upon receiving a claim, the Plan Administrator will review the claim and determine whether the claimant is entitled to receive any benefits pursuant to such claim. The Plan Administrator will notify the claimant in writing of any adverse decision with respect to his or her claim within 30 days after its submission. The notice of any adverse decision will be written in a manner calculated to be understood by the claimant and must include, as applicable: (i) the specific reason or reasons for the denial; (ii) specific references to the Plan provisions on which the denial is based; (iii) 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 (iv) an explanation of the Plan's claim review procedures.

2. If the circumstances require an extension of time for processing the initial claim, a written notice of the extension will be furnished to the claimant before the end of the initial 30-day period. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The extension notice must indicate the circumstances requiring an extension of time.

3. If a claim for benefits is denied or if the Plan Administrator has given no response to such claim within the time period set out in the above paragraph (in which case the claim for benefits will be deemed to be denied), the claimant or his or her duly authorized representative, at the claimant's sole expense, may appeal the denial by submitting written notice of such appeal to the Plan Administrator within 90 days of the receipt of written notice of the denial or 60 days from the date such claim is deemed to be denied.

4. The claimant will be notified of the decision on the appeal within 90 days of receipt of the notice of appeal, unless circumstances require an extension of time for processing, in which case a decision will be rendered as soon as possible, but not later than 120 days after receipt of a notice of appeal. If such an extension of time is required, written notice of the extension will be furnished to the claimant before the end of the original 90-day period. The notice of decision on the appeal must be made in writing. If the decision on the appeal is not furnished within the time specified above, the appeal of the claim will be deemed denied.

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ALAMEDA COUNTY TRANSPORTATION COMMISSION

RESOLUTION 21-009

Restating the Cafeteria Plan of the Alameda County Transportation Commission

Whereas, Alameda County Transportation Commission ("Alameda CTC") adopted the Alameda County Transportation Commission Cafeteria Plan ("the Plan"), effective February 1, 2012;

Whereas, the Plan was designed to permit an eligible employee to pay for his or her share of contributions for options allowed in the Plan on a pre-tax, salary reduction basis, and to contribute on a pre-tax, salary reduction basis to an employee's account for reimbursement of certain medical care expenses and/or to an account for reimbursement of certain dependent care expenses;

Whereas, all full-time employees are eligible to participate in the Plan;

Whereas, Alameda CTC's governing body ("Commission") has determined it to be in the best interest of the Alameda CTC to restate the Plan for 2020 to include provisions allowed in the Consolidated Appropriations Act, 2021 IRS Notice 2021-15; and

Whereas, the Commission has further determined it to be in the best interest of the Alameda CTC to restate the Plan for 2021 to include provisions allowed in the Consolidated Appropriations Act, 2021 IRS Notice 2021-15, and the American Rescue Plan of 2021.

Now, Therefore, Be It Resolved by the Commission of the Alameda CTC as follows:

A. Amendment of Cafeteria Plan

Section 1. Effective January 1, 2020, the Commission hereby amends the Alameda County Transportation Commission Cafeteria Plan, substantially in the form attached as Exhibit A, to permit provisions allowed for in the Consolidated Appropriations Act and 2021 IRS Notice 2021-15; and

Section 2. Effective January 1, 2021, the Commission hereby amends the Alameda County Transportation Commission Cafeteria Plan, substantially in the form attached as Exhibit B, to permit provisions allowed for in the Consolidated Appropriations Act, 2021 IRS Notice 2021-15, and the American Rescue Plan of 2021.

DULY PASSED AND ADOPTED by the Alameda County Transportation Commission at the regular meeting of the Commission held on Thursday, May 27, 2021 in Oakland, California, by the following votes:

AYES: NOES: ABSTAIN: ABSENT:

SIGNED: ATTEST:

_____ _____

Pauline Russo Cutter
Chair, Alameda CTC

Vanessa Lee
Clerk of the Commission