CITY OF CHICAGO

PRE-TAX CONTRIBUTION PLAN

(AS AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2019)

TABLE OF CONTENTS

ARTICLE 1 - INTRODUCTION

1.1 PurposeThe City of Chicago Pre-Tax Contribution Plan (the "Plan") has been established by the City of Chicago (the "City") to provide its eligible employees a choice between certain non-taxable and taxable benefits. The Plan is maintained for the exclusive benefit of eligible employees of the City and is intended to meet the requirements of, and to constitute, a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and any comparable section or sections of any future legislation that amends, supplements or supersedes said section of the Code.

1.2 Effective Date and Plan YearThe "Effective Date" of the Plan as set forth herein is January 1, 2007, and the Plan is amended and restated effective as of January 1, 2019, or as otherwise provided in the Plan with respect to individual provisions. A "Plan Year" is the 12-consecutive month period beginning on each January 1 and ending on the next following December 31.

1.3 AdministrationThe Plan will be administered by the City or any person, persons or entity so designated by the City to serve as Plan Administrator. If no Plan Administrator is designated by the City, the City, itself, is deemed to be the Plan Administrator. Any notice or document required to be given to or filed with the City will be properly given or filed if delivered or mailed by registered mail, postage prepaid, to the City at 333 South State Street, Room 400, Chicago, Illinois 60604.

ARTICLE 2 - ELIGIBILITY AND PARTICIPATION

2.1 EligibilityEach employee of the City who is eligible to participate in the City's group medical plan shall be eligible to become a Participant in the Plan as of the later of (i) the Effective Date, or (ii) the first day of the month following the employee’s commencement of employment with the City, with actual enrollment to occur as soon as practicable following the

employee's completion of the on-line or telephone enrollment process. Notwithstanding the foregoing, an employee who is a Sworn Police Officer below the rank of Sergeant represented by the Fraternal Order of Police will not be eligible to participate in the Dependent Care Reimbursement Account benefits provided under Supplement C of the Plan.

2.2 Cessation of ParticipationA Participant will cease to be a Participant as of the earlier of (i) the date on which the Plan terminates, (ii) the date on which the Participant ceases to be an employee eligible to participate under Section 2.1, (iii) the date of the Participant's death, subject to Section 2.4, or (iv) the date the Participant ceases to make any contributions to the Plan. Notwithstanding the preceding sentence, a Participant, his spouse and dependents may be entitled to continue participation under the Plan with respect to the Health Care Flexible Spending Account as described in Supplement B pursuant to Section 3.3 of this Plan and the requirements of Code Section 4980B and regulations issued thereunder, and the Public Health Service Act, ("PHSA COBRA").

If a Participant terminates employment, the Participant's pre-tax group medical, vision, and dental insurance contributions under the Plan (if any) will cease (unless, as described above, the Participant receives some form of salary continuation, such as severance pay, and is entitled and elects to continue group medical and/or dental insurance). Additionally, the Participant's contributions (if any) to the Dependent Care Reimbursement Account and the Health Care Flexible Spending Account will cease (unless he is entitled to and elects PHSA COBRA continuation coverage with respect to the Health Care Flexible Spending Account).

2.3 Reinstatement of Former ParticipantIf the Participant terminates employment and then is rehired during the same Plan Year, the Participant's pre-tax insurance elections (if any) in the Plan and his elections with respect to contributions to the Dependent Care Reimbursement

Account and the Health Care Flexible Spending Account (if any) will be reinstated automatically for the remainder of the Plan Year. However, if the Participant is rehired more than thirty days after his termination, he shall be eligible to make new elections for the remainder of such Plan Year. If such reinstatement occurs after the end of the Plan Year in which the Participant's termination occurred, the Participant shall be eligible to participate in the Plan after he has satisfied the eligibility requirements of Section 2.1 of the Plan subsequent to his date of rehire.

2.4 DeathIf a Participant dies, his participation in the Plan shall cease. However, a representative of the Participant's estate may submit claims for expenses or benefits incurred during the portion of the Plan Year preceding the Participant's date of death. Additionally, the Participant's spouse and dependents may be entitled to continue coverage under the Health Care Flexible Spending Account pursuant to Section 3.3.

ARTICLE 3 - CONTRIBUTIONS

3.1 Contributions by ParticipantsEach Participant may elect in writing to reduce his future annual compensation from the City in such amount as the Participant designates (not to exceed the maximum amounts specified in the Supplements attached hereto) for any or all of the benefits available under the Plan. Any compensation reduction election shall be made in accordance with the policies and procedures established from time to time by the City. A compensation reduction election must be in writing and filed with the City prior to the later of (i) the first day of the Plan Year for which it is to be effective (or such earlier date established by the City in order to allow adequate time for processing), or (ii) for the first year of eligibility, the thirtieth (30th) day after a Participant's date of eligibility (with the election to be retroactively applicable to the date of eligibility (if it already has passed), but the compensation reductions to apply only to compensation not yet currently available on the date of the election). For purposes of the pre-tax group medical, dental, and vision insurance benefits under Supplement A, if the

Participant does not complete and return a new election form each plan year, the Participant will be treated as having elected to continue his or her coverage option as in effect on the last day of the preceding plan year. If the cost of participation in the City's contributory medical or dental plan increases or decreases during any Plan Year, and, under the terms of the respective plan, the Participant is required to make a corresponding change in payments, the City may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the contributions to the Plan of affected Participants. In addition, if the cost of participation in the City's contributory medical or dental plan increased during the Plan Year, or any prior Plan Year, and, under the terms of the respective plan, the Participant was required to make a corresponding change in payments, but the City inadvertently failed to implement such change or did not become aware of such change until after the fact (for example, because of the retroactive effects of collective bargaining), the City may, on a reasonable and consistent basis, require the Participant to pay the difference. One (but not the only) means for doing so would be to enter into a payment plan whereby any past-due payments that were required to be paid by the Participant are withheld from the Participant's pay over a reasonable period of time. Another approach would be for the City to deduct any past due payments from a paycheck covering a retroactive pay increase.

3.2 Irrevocability of Election by the Participant During the Plan YearAn election of benefits made under the Plan shall be irrevocable by the Participant during the Plan Year for which made, except as provided herein. A Participant may revoke a benefit election for the balance of a Plan Year and file a new election only in the following circumstances:

(a) HIPAA Special Enrollment: A Participant may revoke an existing election and make a new election that corresponds with special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended.

(b) Changes in Status: A Participant may revoke a benefit election for the balance of a Plan Year and file a new election if both the revocation and the new election are on account of and consistent with a change in status that affects eligibility of the Participant, his spouse or dependent for coverage under an employer's cafeteria plan or other employee welfare benefit plan in which the individual is a participant. A change in status for this purpose includes:

(1) a change in legal marital status, including the Participant's marriage, death of the Participant's spouse, divorce, legal separation or annulment;

(2) an event that changes a Participant's number of dependents, including birth, death, adoption and placement for adoption, or an event that otherwise results in an increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the Plan;

(3) a change in employment status of the Participant or the Participant's spouse or dependent including the termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, a reduction or increase in hours of employment, including a switch from part-time to full-time employment status or vice versa, or a switch from hourly to salaried employment or vice versa;

(4) an event causing the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the medical or dental plan under which the Participant receives coverage for that dependent;

(5) a change in the place of residence of the Participant, the Participant's spouse or dependent that effects eligibility; and

(6) such other events as the Plan Administrator determines qualify as a change in status, consistent with regulations and rulings of the Internal Revenue Service.

(c) Reduction of weekly hours of employment below 30: A Participant may revoke an existing election and make a new election where he experiences a reduction in hours of employment such that (1) the Participant reasonably is expected to work an average of less than 30 hours per week after reasonably having been expected to average at least 30 hours per week (even if the reduction in hours of employment does not result in the Participant's ceasing to be eligible under the City's group medical, vision,

and dental plan); and (2) the revocation of a benefit election under the Plan corresponds to the intended enrollment of the Participant and the Participant's spouse or dependent, who cease coverage due to the revocation, in another plan that provides minimum essential coverage, where such new coverage is effective no later than the first day of the second month following the month that includes the date the benefit election is revoked;

(d) Enrollment in a Qualified Health Plan: A Participant may revoke an existing election and make a new election that corresponds with his enrollment in a "Qualified Health Plan" (as purchased through a marketplace established pursuant to Section 1131 of the Patient Protection and Affordable Care Act of 2010 (a "Marketplace")), where (1) the Participant is eligible for a "special enrollment period" to enroll in a Qualified Health Plan pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Marketplace during the Marketplace's annual open enrollment period; and (2) the revocation of a benefit election under the Plan corresponds to the intended enrollment of the Participant and the Participant's spouse or dependent, who cease coverage due to the revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the revoked coverage;

(e) PHSA COBRA Eligibility: In the event a Participant, a Participant's spouse or dependent becomes eligible for continuation coverage under the City's group medical or dental plan, the Participant may elect to modify payments under the Plan as appropriate in order to pay for the continuation coverage elected.

(f) Court Order: Upon the entry of a judgment, decree or court order (including a qualified medical child support order under Section 609 of the Employee Retirement Income Security Act of 1974) resulting from a divorce, legal separation, annulment or change in legal custody requiring the Participant or the Participant's former spouse to provide, or cancel, health coverage for a Participant's child or for a foster child who is a dependent of the Participant, a Participant may make a corresponding change in election (cancellation to be permitted only if the order also requires another person to provide coverage for the child and such coverage actually is provided).

(g) Entitlement to Medicare/Medicaid: In the event the Participant or the Participant's spouse or dependent becomes entitled to or loses eligibility for coverage under Medicare or Medicaid, then the Participant may cancel, reduce, commence or increase coverage for himself, his spouse or his dependent accordingly.

(h) Significant Change in Cost or Coverage: Other than with respect to the Health Care Flexible Spending Account provided for in Supplement B,

(1) if the cost to the Participant (if any) for a benefit package option (e.g., a benefit offered through this Plan, or an option for coverage under an underlying medical plan, such as an indemnity option, an HMO option, or a PPO option) significantly increases or decreases (whether that increase or decrease results from an action taken by the employee or from an action taken by the City), or, with respect to the Dependent Care Reimbursement Account election, a significant cost change is imposed by a dependent care provider who is not a relative of the Participant, a Participant may make a corresponding election change for the balance of the Plan Year;

(2) if coverage under the City's medical or dental plan or a plan of an employee's spouse or dependent, is significantly curtailed or ceases (for example, there is a significant increase in the deductible, copay or out-of-pocket cost sharing limit under a health plan) during such Plan Year, but there is not a loss of coverage as defined in (3) below, an affected Participant may revoke his election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage, provided such changes are permitted under the terms of the applicable benefit plan;

(3) if a Participant or his spouse or dependent has a significant curtailment of coverage that is a loss of coverage (that is, a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation)), the affected Participant may revoke his election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available, provided such changes are permitted under the terms of the applicable benefit plan;

(4) if a new benefit package option or other coverage option is added or if coverage under an existing benefit package option or other coverage option is significantly improved, a Participant may revoke his election, and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit package option, provided such changes are permitted under the terms of the applicable benefit plan; or

(5) a Participant may make an election change on account of and corresponding with a change made under the plan of the spouse's, former spouse's or dependent's employer provided the election under the spouse's or dependent's plan satisfies both that plan's election change rules and IRS regulations regarding election changes, or the spouse's or dependent's plan has a different period of coverage.

(i) FMLA: Family Medical Leave Act.

With respect to a Participant on a paid leave of absence under the Family Medical Leave Act ("FMLA"), the Participant's existing election will remain in effect and the Participant's share of premiums to the Pre-Tax Premium Account and/or contributions to a Health Care Flexible Spending Account will be paid in the same manner as prior to the leave. Additionally, the Participant may make an election change with respect to a Dependent Care Reimbursement Account, provided the change is on account of and consistent with the leave. The Participant will not be entitled to reimbursement of Dependent Care claims incurred during an FMLA leave.

With respect to a Participant on an unpaid FMLA leave of absence, the Participant may revoke an existing election or continue coverage during the leave with respect to health benefits (such as medical or dental benefits) under the City's health plans or with respect to the Health Care Flexible Spending Account. If the Participant elects to continue coverage, the Participant may pay his share of premium payments and contributions on a monthly basis on the first of every month (the same schedule as PHSA COBRA payments). These payments typically would be made on an after-tax basis, unless the Participant receives taxable compensation during the leave period (e.g., as a result of unused sick days or vacation days). The City may cancel the Participant's coverage retroactive to the beginning of the period for which a payment was due if a Participant fails to make any payment before the end of the grace period for payment, provided that with respect to Participants on an FMLA leave, the City notifies such Participants of the overdue payment at least 15 days before the end of such grace period. Alternatively, the City, at its option, may continue coverage during the leave and then recoup the Participant's share of premiums and contributions from available taxable compensation upon the Participant's return from leave.

If the Participant does not elect to continue coverage while on FMLA leave, the Participant will be entitled to reinstatement upon return to employment on the same terms as prior to taking FMLA leave, subject to any changes in benefit levels that may have taken place during the leave. Upon reinstatement in the Health Care Flexible Spending Account, the Participant may elect in writing to resume coverage at the level in effect

before the FMLA leave and makeup the unpaid missing contributions; otherwise coverage will resume at a level that is reduced and premium payments will resume at the level in effect before the FMLA leave. If the Participant does not elect to continue coverage during the FMLA leave under the Health Care Flexible Spending Account while on FMLA leave, the Participant will not be entitled to reimbursement for claims incurred during the FMLA leave.

Any election change (other than those made in connection with a court order or as an exercise of rights pursuant to a statute that provides for a specific election period such as HIPAA or PHSA COBRA) must be requested within thirty (30) days from the date of the change event (or within such other reasonable period as permitted by the Plan). Any new election shall be effective not earlier than the first pay period covered by the new salary reduction election, unless an earlier effective date is required by HIPAA or other applicable law. Additionally, a Participant may not make any change that would reduce the Participant's level of Health Care Flexible Spending Account coverage under Supplement B to an amount that would be less than the amount of benefits claimed under such coverage as of the date the change would become effective.

3.3 Continuation of CoverageA Participant shall be entitled to continue participation for such benefits under the Plan as required pursuant to and consistent with the continuation coverage requirements of PHSA COBRA. In particular, PHSA COBRA requires that Participants with positive Health Care Flexible Spending Account balances be permitted to continue participation with respect to the Health Care Flexible Spending Account component of the Plan described in Supplement B through the remainder of the Plan Year in which a qualifying event that otherwise would result in a loss of coverage has occurred.

(a) A “qualifying event” in the case of a Participant is a reduction in hours of employment or the termination of employment (for reasons other than gross misconduct).

(b) A "qualifying event" in the case of a spouse of a Participant is the death of the Participant, divorce or legal separation from the Participant, or the reduction in the Participant's hours of employment or the termination of the Participant's employment (for reasons other than gross misconduct).

(c) A "qualifying event" in the case of the Participant's dependent child is the death of the Participant, the divorce of the dependent's parents, the reduction in the Participant's hours of employment, the termination of the Participant's employment (for reasons other than gross misconduct), or the dependent ceasing to be eligible as a "dependent" under the City's group medical or dental plan.

(d) Under PHSA COBRA, the Participant, his spouse or dependent has 60 days from the later of the date the person would lose coverage as a result of the qualifying event and the date that the Plan provides notice to the family of their PHSA COBRA rights in which to elect to continue coverage. PHSA COBRA coverage under the Health Care Flexible Spending Account may be continued until the end of the Plan Year in which the qualifying event occurred. Continuation coverage may end if the cost of the continuation coverage is not paid in a timely fashion or if the Health Care Flexible Spending Account component of the Plan is discontinued with respect to all employees. Additional information about PHSA COBRA will be provided to Participants and their families in the notices that are distributed when the Participant first becomes eligible to participate in the Plan and again upon the occurrence of a qualifying event.

(e) A Participant who elects to continue coverage under the Health Care Flexible Spending Account or who elects to continue coverage under the City's group medical or dental plan pursuant to PHSA COBRA. Alternatively, a Participant may make after-tax contributions for such benefits. All such payments shall be made in accordance with the written policies and procedures as may be established by the City from time to time.

ARTICLE 4 - PAYMENT OF BENEFITS

4.1 Covered BenefitsAn account will be established for each Participant (with separate sub-accounts established for each benefit elected by the Participant) to which is credited the Participant's contributions for such benefit and from which is charged disbursements for the benefit. To the extent of the credited balance in the applicable sub-account, the City shall pay the covered expenses of each benefit selected by a Participant as such expenses are incurred

during such Plan Year. Notwithstanding the foregoing, expenses incurred as a result of advance payment for covered orthodontia services and durable medical equipment may be reimbursed from the Health Care Flexible Spending Account before such services and equipment actually are received. The covered expenses, when paid, shall be charged against such Participant's sub-account and shall reduce the balance thereof. Notwithstanding the preceding, a Participant shall be entitled to receive reimbursement up to the entire amount the Participant has elected under the Health Care Flexible Spending Account for the Plan Year. This amount shall be available as of the first day of the Plan Year. Only substantiated covered expenses incurred on or after the later of the (i) Plan's Effective Date and (ii) the date the Participant is enrolled in the Plan shall be paid or reimbursed.

4.2 Insurance BenefitsThe rights and conditions with respect to any benefits payable from group medical, vision, and dental insurance contracts selected by the City shall be determined solely with respect to such insurance contracts. The City shall not be responsible for the validity of any insurance contract issued hereunder or for the failure on the part of any insurer issuing such insurance contract to make any payments thereunder or for the action of any person which may delay or render null and void or unenforceable, in whole or in part, any insurance contract. The rights and conditions with respect to any benefits payable from any self-insured group medical or dental plan shall be determined solely pursuant to the provisions of that plan's documents.

ARTICLE 5 - GENERAL PROVISIONS

5.1 Information to be Furnished by ParticipantsParticipants shall furnish to the City such documents, receipts, expense reports, evidence, data or information as the City considers necessary or desirable for the purpose of administering the Plan. In order to receive benefits

under the Plan, a Participant must furnish full, true and complete evidence satisfactory to the City and must promptly sign any document related to the Plan requested by the City.

5.2 Uniform RulesThe City shall administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated.

5.3 Changes by City to Address DiscriminationIf the City determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to "highly compensated" employees or "key employees" as defined under the Code, the City shall take such action as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by highly compensated employees or key employees to reduce the amount of their salary reductions with or without the consent of such Participants.

5.4 Plan Administrator/City Decision FinalThe City or its designated Plan Administrator has discretionary authority to determine eligibility for benefits, to decide claims, and to determine all other matters under the Plan. Benefits under this Plan will be paid only if the City or the designated Plan Administrator decides in its discretion that the applicant is entitled to them. Any interpretation of the provisions of the Plan by the City or the Plan Administrator and any decision made by the City or Plan Administrator on any matter within its respective discretion shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known and the City or Plan Administrator shall make such adjustment or account thereof as it considers equitable and practicable. Neither the City nor the Plan Administrator shall be liable in any manner for any determination of fact made in good faith.

5.5 Gender and NumberWhere the context permits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural, and the plural shall include the singular.

5.6 Severability of ProvisionsIn the event that any provision of the Plan shall be held to be illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions but shall be fully severable, and the Plan shall be construed and enforced as if said illegal invalid provision had never been inserted therein.

5.7 Binding EffectThe Plan and all actions and decisions hereunder, shall be binding upon the heirs, executors, administrators, successors and assigns from any and all parties hereto and Participants, present and future.

5.8 Headings of Articles and SectionsThe headings of Articles and Sections are included solely for the convenience of reference, and if there is any conflict between such headings and the text of the Plan, the text shall control.

5.9 Controlling LawExcept to the extent preempted by the laws of the United States, the laws of the State of Illinois shall be controlling in all matters relating to the Plan.

5.10 Employment RightsThe Plan does not constitute a contract of employment, and participation in the Plan will not give any employee the right to be retained in the employ of the City, nor any right or claim to any benefit under the Plan, unless such right or claim has specifically accrued under the terms of the Plan.

5.11 Indemnification of Plan AdministratorThe City agrees to indemnify and to defend to the fullest extent permitted by law any employee serving as the Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all

liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the City) occasioned by any act or omission to act in connection with the Plan, if such act or omission was in good faith.

5.12 Cost of Plan AdministrationThe cost and expenses incurred by the City in administering the Plan shall be paid by the City.

5.13 EvidenceAny evidence required of anyone under the Plan may be by certificate, affidavit, document or other information that the person acting on it considers pertinent and reliable, and signed, made or presented by the proper party or parties, or in such other form as the City may prescribe or deem satisfactory.

5.14 Interests Not TransferableThe interests of Participants under the Plan are not subject to the claims of their creditors and may not be transferred or encumbered.

5.15 Facility of PaymentWhen, in the City's opinion, a Participant is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the City may (but need not) make payments reimbursing such Participant's expenses to the Participant's legal representative, or to his spouse, or the City may apply the payment for the benefit of the Participant in any way the City considers advisable.

5.16 No Guarantee of Tax ConsequencesNeither the Plan Administrator nor the City 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 shall 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.

5.17 Indemnification of EmployerIf 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 shall indemnify and reimburse the City for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

5.18 Delegation of AuthorityWhenever the City under the terms of this document is permitted or required to perform any action or service, such action or service shall be done and performed by any officer or individual representative of the City who is duly authorized by the City or another individual to whom the City has properly assigned or delegated such duties.

5.19 Misrepresentations or FraudIf a Participant deliberately defrauds or misleads the Plan Administrator about the eligibility or entitlement to benefits of himself or another person, the Plan Administrator has the right to terminate Plan coverage for that Participant and/or any family members immediately and retroactively. The Plan shall be entitled to recover (including by means of offset against future benefits or by withholding from future compensation, to the extent permitted by law) from the Participant and/or his family members any claims mistakenly paid due to mistake, fraud or a wrongful attempt to procure coverage, and to recover any costs and expenses arising from such fraud or misrepresentation, including, but not limited to, costs and expenses recoverable in actions at law and in equity. Additionally, fraud on the part of the Participant shall be grounds for disciplinary action up to and including termination of employment.

ARTICLE 6 - AMENDMENT AND TERMINATION

6.1 AmendmentWhile the City expects and intends to continue the Plan, the City expressly reserves the right, in its sole and unrestricted discretion, to amend the Plan at any time, except that any amount which had become payable under the Plan prior to the date an

amendment is effective shall be paid or payable in accordance with the terms of the Plan as in effect immediately prior to the date of the amendment. Unless otherwise provided under the Plan, all amendments to the Plan must be in writing and shall be prospective in nature.

6.2 TerminationThe Plan may be terminated at any time by the City.

6.3 Benefits on TerminationOn termination of the Plan, any amounts that became payable under the terms of the Plan prior to the date of termination shall be paid in accordance with the terms of the Plan as in effect prior to the date of such termination.

ARTICLE 7 - COMPLIANCE WITH THE HIPAA PRIVACY AND SECURITY RULE

7.1 PurposeThis Section, in compliance with the Privacy Rule and the Security Rule contained in the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder found at 45 C.F.R. Parts 160, 162 and 164 ("HIPAA"), is intended to allow disclosure of Protected Health Information ("PHI") including electronic PHI as defined under HIPAA, to the City of Chicago (the "Plan Sponsor") for the purposes specified below.

Generally, PHI, as defined under HIPAA, includes all individually identifiable information related to an individual's past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form. PHI does not include information that has been de-identified. De-identified information is information that does not identify the individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

Electronic PHI ("ePHI") refers to PHI that is transmitted by or maintained in electronic media including electronic storage media (such as hard drives, magnetic tapes or disks, optical disks, and digital memory cards) and electronic transmission media (such as the Internet,

extranets, leased lines, dial-up lines, private networks, telephone voice response systems and faxback systems, but not paper-to-paper faxes or voicemail messages).

This Section applies only to the "health care components" of the Plan as that term is defined in 164 CFR §504 of the Privacy Rule contained in the Administrative Simplification Provisions of HIPAA. In other words, only the Health Care Flexible Spending Account benefits provided pursuant to Supplement B are designated as health care components of the Plan.

To the extent that there is any conflict between this Section and any other Plan provisions, the terms of this Section as set forth below control. The Plan Administrator and its duly authorized representatives retain full discretion in interpreting and applying these rules.

7.2 Disclosure of PHI to CityPlan may disclose PHI to the City in the following circumstances:

- Plan receives an authorization from the individual to disclose PHI to the City.
- Plan discloses information to the City on whether an individual is participating in the Plan.
- Plan also may provide summary health information to the City so that the City may modify, amend or terminate the Plan. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by the individuals for whom the City has provided health benefits under the Plan, from which individual identifiers (other than certain limited geographical information), such as names and social security numbers, have been removed.

Otherwise, Plan shall disclose PHI to the City only to the extent necessary for the City to perform administrative functions on behalf of the Plan. (If the City does not perform such functions, Plan will not disclose PHI to the City other than as indicated above.) Administrative functions include activities that would meet the definition under the HIPAA Privacy Rule of treatment, payment, and health care operations activities. Such activities include, but are not limited to, the following:

- Review and resolution of claims for benefits and appeals
- Determinations with respect to eligibility and coverage
- Determining employee contribution rates
- Quality assessment
- Auditing, monitoring, and fraud detection and investigation programs
- Cost management
- Solicitation of proposals for services to be provided to or on behalf of the Plan
- Related computer and systems programming and development.

Notwithstanding anything to the contrary, in no event shall the City be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA.

7.3 Plan Sponsor CertificationThe Plan agrees that it will disclose PHI to the City only upon receipt of a certification that this Plan document incorporates the following provisions and that the City agrees to abide by such provisions:

(a) Prohibition on Unauthorized Use or Disclosure of PHI. The City will not use or disclose any PHI received from the Plan, except as permitted in the Plan documents or as required by law.

(b) Agents (Including Subcontractors). The City will require each of its agents, including subcontractors, to whom the City provides PHI that it received from the Plan, to agree to the same restrictions and conditions that apply to the City with respect to such information.

(c) Impermissible Purposes. The City will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the City's benefits or employee benefit plans.

(d) Reporting. The City will report to the Plan any use or disclosure of PHI, of which it becomes aware, that is inconsistent with the uses and disclosures permitted by the Plan. Specifically, the Plan Sponsor will report to the Plan any Breach as defined by 45 CFR § 164.402.

(e) Access to PHI by Participants. The City will make PHI available to the Plan to permit Participants upon request to inspect and copy their PHI to the extent provided by 45 CFR § 164.524.

(f) Amendment of PHI. The City will make PHI available to Participants who request to amend or correct PHI that is inaccurate or incomplete and will incorporate any amendments to PHI to the extent required and/or permitted by 45 CFR § 164.526.

(g) Accounting of PHI. The City will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Disclosure to the Secretary. The City will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA.

(i) Breach Notification. The Plan Sponsor will cooperate with the Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.

(j) Return or Destruction of PHI. When the PHI is no longer needed for the purpose for which disclosure was made, the City must, if feasible, return to the Plan or destroy all PHI that the City received from the Plan, and retain no copies in any form. If return or destruction is not feasible, the City agrees to limit further uses and disclosures to the purposes that make the return or destruction infeasible.

(k) Adequate Separation. The City must ensure that adequate separation exists between the Plan and the City so that PHI will be used only for plan administration. The following employees, classes of employees or persons under the control of the City may have access to and may use PHI, but only to the extent necessary to perform the administration functions that (i) are to be performed by the City as set forth under (b) above and (ii) are assigned to such employees as a part of their job duties:

- An officer or employee or committee thereof that serves as Plan Administrator;
- An officer or employee who serves as a Plan fiduciary;
- An officer or employee who serves as the Privacy or Security Officer under HIPAA;
- An employee of the Departments of Innovation and Technology, Law, or Finance.

In the event that any such persons do not comply with the requirements set forth herein, such persons shall be subject to disciplinary action by the City for noncompliance, pursuant to the City's discipline and termination

or removal procedures. The City shall take whatever actions necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated or removed pursuant to this paragraph, the Plan reserves the right to direct that the City modify or revoke any person's access to or use of PHI, and the City shall take such action as warranted. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Officer at the telephone number and address provided in the Plan's notice of privacy practices.

(l) Protection of Electronic PHI. If electronic PHI is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor will do the following:

- Ensure that the "adequate separation" described in subparagraph (10) above is supported by reasonable and appropriate security measures;

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such electronic PHI;

- Ensure that any agent (including a subcontractor) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware. For purposes of this provision, "security incident" is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Notwithstanding the above, if the only ePHI that is disclosed to the Plan Sponsor is disclosed pursuant to a HIPAA-compliant authorization or is limited to Summary Health Information (as defined in the Privacy Rule) disclosed for the purpose either of obtaining premium bids for providing health insurance coverage under the Plan, or modifying, amending or terminating the plan, and information regarding an individual's participation, enrollment or disenrollment, the requirements of this subparagraph do not apply.

ARTICLE 8 - EXECUTION OF PLAN

IN WITNESS WHEREOF, the Plan and Supplements A, B, and C are hereby executed effective as of the _____ day of _____, 2019.

CITY OF CHICAGO:

ATTEST:

By: _____ By: _____

Its: _____ Its: _____

SUPPLEMENT A
PRE-TAX PREMIUM ACCOUNT

A-1 Purpose

Each Plan Year, each Participant will be entitled to pay his share (if any) of the premium cost for the elected group medical, vision, and dental insurance coverage for that year with pre-tax dollars through payroll withholding. Salary reduction amounts from the last month of one Plan Year may be applied to pay group medical, vision, and dental insurance premiums for insurance during the first month of the immediately following Plan Year.

A-2 Election of Coverage

In order to elect coverage under the Pre-Tax Premium Account, a Participant on an annual basis must complete the telephone or on-line election process within the applicable period pursuant to Section 3.1 of the Plan. The Participant's election must specify the type of coverage elected and whether pre-tax dollars are to be applied for premium payments. If, for succeeding Plan Years, a Participant does not submit a new election, he will be deemed to have elected the type and level of coverage under the Pre-Tax Premium Account in effect on the last day of the preceding Plan Year.

A-3 Incorporated Plans

The City's group medical, vision, and dental insurance plans to which employees make pre-tax contributions (if any) as adopted by the City, from time to time, are hereby incorporated by reference into the Plan.

A-4 Irrevocable Elections

Any coverage elected under Section A-2 shall be irrevocable for the duration of the Plan Year except in the event of a change in status, or as otherwise provided pursuant to Section 3.2 of the Plan.

SUPPLEMENT B
HEALTH CARE REIMBURSEMENT ACCOUNT

B-1 Purpose

Each Participant will be entitled to choose between (a) reimbursement for "Medical Care Expenses" (as defined below) not reimbursed by any other plan or taken as an income tax deduction, and (b) cash compensation. It is intended that this Health Care Flexible Spending Account (the "Health Care FSA") qualify as a nondiscriminatory cafeteria plan benefit under Code Section 125 and as an accident and health care plan within the meaning of Code Section 105(e) and that reimbursements paid hereunder be eligible for exclusion from the Participant's income under Code Section 105(b).

B-2 Election of Coverage

In order to elect coverage under the Health Care FSA, Participants must complete the telephone or on-line enrollment process within the applicable period pursuant to Section 3.1 of the Plan. Each Participant may designate a minimum of $120 and up to $2,650 (to be adjusted from time to time by the City in is sole discretion based on indexing for inflation pursuant to the Internal Revenue Code) of coverage each Plan Year under a Health Care FSA (the "elected coverage"), and his compensation from the City shall be reduced by the amount of the elected coverage and said amount shall be credited to said Health Care FSA.

B-3 Allowable Benefits Under Health Care FSA

Reimbursements to a Participant shall be permitted hereunder only with respect to “Medical Care Expenses,” that is, amounts expended (and not reimbursed by any other plan or policy or any other source or taken as an income tax deduction) for "medical care" (within the meaning of Code Section 213(d)) of the Participant or the Participant’s tax qualified dependents under Code Section 105(b).

For purposes of a Health Care FSA, examples of Medical Care Expenses are set forth below:

1. Deductibles and co-payments under the City's health plans (including the medical, vision, and dental plans) or under personal accident and health insurance carried by the Participant, his spouse, or covered dependents;
2. Prescription drugs;
3. Over-the-counter drugs and products such as antacids, allergy medicines, pain relievers and cold medicines will not be reimbursed unless the individual has a prescription for such over-the-counter drugs and medicines, except that a prescription is not needed for insulin;
4. Over-the-counter medical devices and supplies;
5. Eye care, including vision checkups, eyeglasses and contact lenses;
6. Hearing care, including hearing examinations and hearing aids; and
7. Routine physical examinations
8. Any other medical care item that constitutes medical care within the meaning of Code Section 213(d).

B-4 Substantiation/Correcting Improper Reimbursements.

A Participant must provide third-party substantiation of any Medical Care Expenses incurred for which reimbursement is sought by the Participant.

In the event that a Medical Care Expense is improperly reimbursed due to insufficient or improper substantiation, overpayment, fraud or otherwise, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under applicable law, seek repayment of such improper reimbursement by (1) requesting the Participant direct payment

to the Plan, (2) withholding the corresponding amount from the Participant's compensation on an after-tax basis (where such withholding is permissible under applicable law), or (3) offsetting the improper reimbursement against other valid Medical Care Expense claims.

B-5 Limitations

For each Plan Year and its related Grace Period (as defined in Section B-9 below), the Participant may be reimbursed for Medical Care Expenses up to the full amount of elected coverage the Participant has elected for the Plan Year less any prior reimbursements for this period. The amount of elected coverage by a Participant for a Plan Year is only available to reimburse expenses that are incurred during the Plan Year during which an election is in effect hereunder and its related Grace Period. Participants shall have until March 31 following the end of the Plan Year to submit claims for such expenses. An expense is incurred during the Plan Year or its related Grace Period if the services giving rise to the expenses are performed during the Plan Year or its related Grace Period. An expense shall not be deemed to be incurred during the Plan Year or its related Grace Period merely because a Participant receives a bill for the expense during the Plan Year or its related Grace Period or pays for the expense during the Plan Year or its related Grace Period.

B-6 Nondiscrimination Requirements

It is intended that contributions and benefits under the Health Care Flexible Spending Account not be discriminatory under the provisions of the Code. In that regard, notwithstanding anything contained herein to the contrary, the Plan Administrator may limit the amounts reimbursed or paid to any Participant who is considered a highly compensated individual under Code Sections 105(h)(5) or 125(e) or to any Participant who is considered a key employee under

Code Section 125(b)(2) to the extent the Plan Administrator deems such limitation advisable to comply with any restrictions contained in the Code.

B-7 Forfeiture

Unless as otherwise provided in Section B-11, if a Participant incurs during the Plan Year and its related Grace Period (as defined in Section B-9 below) aggregate expenses qualifying for reimbursement less than the dollar amount of coverage the Participant elects for such Plan Year, any remaining amount in the Participant's Health Care FSA as of the end of the Grace Period for that Plan Year shall be forfeited. Any amount of coverage for a Plan Year that is unused due to the Participant's failure to submit proper claims for reimbursements in conformity with the procedure prescribed by the Plan also shall be forfeited. Subject to the requirements of applicable law, forfeitures will be retained by the City to defray Plan administrative expenses, reduce required salary reduction amounts for the next Plan Year on a reasonable and uniform basis, or be allocated to participating employees on a reasonable and uniform basis.

B-8 Irrevocable Elections

Any coverage elected under Section B-2 shall be irrevocable for the duration of the Plan Year except in the event of a change in status, or as otherwise provided pursuant to Section 3.2 of the Plan.

B-9 Special Rules for Expenses Incurred During the Grace Period

This section contains special provisions that are intended to incorporate the grace period permitted by Internal Revenue Service Notice 2005-42, 2005-23 I.R.B. 1204. The provisions of this Section shall operate in conjunction with other Plan provisions. In case of conflict or ambiguity between this section and other provisions of the Plan, the Plan shall be administered in

accordance with the intention of this Section, as stated above, to the extent permitted under applicable law, regulatory requirement, or published tax guidance.

Notwithstanding any provision in the Plan to the contrary, the Plan shall reimburse the expenses of any Participant incurred during the applicable Grace Period, to the extent they are otherwise eligible for reimbursement under the terms of the Plan. For this purpose, the term "Grace Period" shall mean the period from January 1st to March 15th immediately following the close of each Plan Year. Unless a debit card is used to submit expenses, eligible expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts from the elected amount remaining at the end of the preceding Plan Year and then from any amounts from the elected amount that are available to reimburse expenses incurred during the current Plan Year.

B-10 Run-Out Period

A Run-Out Period is a period after the end of the Plan Year during which a Participant can submit a claim for reimbursement for a qualified benefit incurred during the Plan Year (or Grace Period). Notwithstanding any provision in the Plan to the contrary, the Plan shall reimburse the expenses of any Participant submitted during the applicable Run-Out Period, to the extent they are otherwise eligible for reimbursement under the terms of the Plan. For this purpose, the term "Run-Out Period" shall mean the period from January 1 to March 31 immediately following the close of each Plan Year.

B-11 Qualified Reservist Distributions

This Section contains special provisions that are intended to incorporate qualified reservist distributions permitted by the Heroes Earnings Assistance and Relief Tax Act of 2008, P.L. 110-245 (the "HEART Act"). The provisions of this Section shall operate in conjunction

with other Plan provisions. In case of conflict or ambiguity between this section and other provisions of the Plan, the Plan shall be administered in accordance with the intention of this Section, as stated above, to the extent permitted under applicable law, regulatory requirement, or published tax guidance.

Notwithstanding any provision in the Plan to the contrary, the Plan shall distribute to a Participant all or a portion of the balance in the Participant's Health Care FSA if:

(a) such Participant is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period, and

(b) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made for the Plan Year which includes the date of such order or call.

No qualified reservist distributions shall be paid on behalf of anyone other than a Participant who is ordered or called to active duty. The Participant ordered or called to active duty must provide the City with a copy of the order or call to active duty before an amount may be distributed. The request for a qualified reservist distribution must be made on or after the date of the order or call to active duty, and before the last day of the Plan Year or applicable Grace Period during which the order or call to active duty occurred. Qualified reservist distributions shall be paid no later than sixty days after the date of the request for a qualified reservist distribution.

For purposes of making a qualified reservist distribution, the Participant's Health Care FSA balance available for such a distribution will be the amount contributed to the Health Care FSA as of the date of the qualified reservist distribution request minus Health Care FSA reimbursements received as of the date of the qualified reservist distribution request.

A qualified reservist distribution will not be made with respect to amounts (1) attributable to a prior plan year (including a plan year ending on or before June 18, 2008), or (2) attributable to non-Health Care FSAs.

With respect to medical expenses incurred after the date a qualified reservist distribution is requested, the Plan will terminate the Participant's right to submit claims.

SUPPLEMENT C
DEPENDENT CARE REIMBURSEMENT ACCOUNT

C-1 Purpose.

Each eligible Participant will be entitled to choose between (a) reimbursement for "Dependent Care Expenses" (as defined below) for which a dependent care tax credit is not taken, and (b) cash compensation. It is intended that the Dependent Care Reimbursement Account (the "Dependent Care Account") qualify as a nondiscriminatory cafeteria plan benefit under Code Section 125 and as a dependent care reimbursement plan within the meaning of Code Section 129 and that reimbursements paid hereunder be eligible for exclusion from Participants' income under Code Section 129(a).

C-2 Election of Coverage

In order to elect coverage under the Dependent Care Account, Participants must complete the telephone or on-line enrollment process within the applicable period pursuant to Section 3.1 of the Plan. Each Participant may designate a minimum of $120 or up to $5,000 ($2,500 where the Participant is married and files a separate return) of coverage (the "elected coverage"), provided however, that each Participant's elected coverage under the Dependent Care Account shall be limited to the lesser of (a) the Participant's Earned Income for the Plan Year, or (b) the Participant's spouse's Earned Income for the Plan Year. For purposes of this Supplement C, Earned Income means the individual's compensation from the individual's employer plus the amount of the individual's net earnings from self-employment during the Plan Year, computed without regard to any community property laws, without taking into account any amount received as a pension or annuity, and without taking into account any amounts paid under the Plan or under a dependent care reimbursement plan of any other employer. If the Participant's spouse is a Qualifying Individual or is a full-time student (as defined in Code Section 21(d)(2)),

such spouse will be deemed to have Earned Income for purposes of this Supplement for each month during the Plan Year in which the spouse has such status, equal to either (1) $200, if there is one Qualifying Individual with respect to the Participant; or (2) $400, if there is more than one Qualifying Individual with respect to the Participant. The $5,000 limit shall be reduced by the amount of dependent care assistance received under a plan of the employer of the Participant's spouse. The Participant's compensation from the City shall be reduced, by the amount of the elected coverage, in equal amounts each payroll period and shall be credited each payroll period to the Participant's Dependent Care Account.

C-3 Allowable Benefits Under The Dependent Care Account

Reimbursements to a Participant shall be permitted hereunder only with respect to Dependent Care Expenses which are incurred while an election is in effect either during the Plan Year or, if shorter, during the Participant's period of employment within the Plan Year, for which a dependent care tax credit is not taken on the Participant's income tax return, up to the amount of coverage elected by the Participant for the Plan Year. Dependent Care Expenses shall include only amounts paid which constitute "employment related expenses" within the meaning of Code Section 21. Dependent Care Expenses must be incurred for the care of a Qualifying Individual ((i) a child of a Participant who is under the age of thirteen (13) and with respect to whom the Participant is entitled to the deduction under Code Section 151(c), or, (ii) a “Dependent” (as defined in Code Section 152, except if the Participant is divorced then as defined in Code Section 21(e)(5)) or the Participant's spouse who is physically or mentally incapable of caring for himself, provided that such persons share the same principal place of abode with the Participant for more than one-half of the year) and to enable the Participant to be gainfully employed. Dependent Care Expenses shall be limited to: (a) amounts paid for services rendered in the

Participant's home; or (b) amounts paid for services rendered outside of the Participant's home only if such services are provided for the care of a Qualified Individual who is under age thirteen (13), or who is age thirteen (13) or older and who regularly spends at least eight (8) hours a day in the Participant's home provided that services rendered in a dependent care center (as defined in Code Section 21) must satisfy the requirements of Code Section 21 and the regulations promulgated thereunder.

C-4 Limitations

For each Plan Year, the Participant may be reimbursed for Dependent Care Expenses up to the dollar amount of elected coverage the Participant has accumulated in his Dependent Care Account through contributions to that date less any prior reimbursements for this period. If the Participant's expenses exceed the accumulated amount to date, the Participant will receive additional reimbursements hereunder as the Participant accumulates additional funds in his Dependent Care Account. The amount of elected coverage by a Participant for a Plan Year is only available to reimburse expenses that are incurred during the Plan Year during which an election is in effect hereunder. Participants shall have until March 31 following the end of the Plan Year to submit claims for these expenses. An expense is incurred during the Plan Year if the services giving rise to the expense are performed during the Plan Year. An expense shall not be deemed to be incurred during the Plan Year merely because a Participant receives a bill for the expense during the Plan Year or pays for the expense during the Plan Year.

C-5 Nondiscrimination Requirements

It is intended that contributions and benefits under the Dependent Care Reimbursement Account not be discriminatory as prohibited by Code Section 129(d). In particular, the average benefits provided to non-highly compensated employees (excluding, in the Plan Administrator’s

discretion, employees earning less than $25,000) must be at least 55% of the average benefits provided to highly compensated employees (as defined in Code Section 414(q)). If the Plan Administrator believes that either of these limits may be exceeded, it may, in its own discretion and notwithstanding anything herein to the contrary, limit the amount of benefits paid with respect to such individuals to the extent the Plan Administrator deems such limitation advisable in order to comply with the restrictions contained herein or any other nondiscrimination provision contained in the Code.

C-6 Forfeiture

If a Participant incurs during the Plan Year aggregate expenses qualifying for reimbursement less than the amount of elected coverage for a Plan Year, any remaining amount in his Dependent Care Account as of the end of the Plan Year shall be forfeited. Any amount of elected coverage for a Plan Year unused due to the Participant's failure to submit proper claims for reimbursements in conformity with the procedures prescribed by the Plan shall also be forfeited. Subject to requirements of applicable law, forfeitures will be retained by the City.

C-7 Irrevocable Elections

Any coverage elected under Section C-2 shall be irrevocable for the duration of the Plan Year except in the event of a change in status, or as otherwise provided pursuant to Section 3.2 of the Plan.

C-8 Spend Down for Terminated Employees

Expenses incurred after the date an employee ceases participation in the Plan (for example, after termination) and through the last day of that Plan Year may be reimbursed from unused benefits.

C-9 Run-Out Period

A Run-Out Period is a period after the end of the Plan Year during which a Participant can submit a claim for reimbursement for a qualified benefit incurred during the Plan Year. Notwithstanding any provision in the Plan to the contrary, the Plan shall reimburse the expenses of any Participant submitted during the applicable Run-Out Period, to the extent they are otherwise eligible for reimbursement under the terms of the Plan. For this purpose, the term "Run-Out Period" shall mean the period from January 1 to March 31 immediately following the close of each Plan Year.

4835-9098-5232.v6