RESOLUTION

HEALTHCARE REIMBURSEMENT PLAN

Note: See Definitions (pages 4-5) for Manager(s), Company, and other definitions.

WHEREAS, the Manager(s) have determined that it would be in the best interests of Company and its employees to adopt a "Healthcare Reimbursement Plan" allowing Company employees to receive reimbursement of specified medical care expenses; be it known that a vote was taken, and all were in favor.

RESOLVED, that Company adopt a "Healthcare Reimbursement Plan" all in accordance with the specifications annexed hereto; and, be it known that the Company "Healthcare Reimbursement Plan" Plan Document was executed on the date below.

RESOLVED FURTHER, that the Manager(s) of the Corporation undertake all actions necessary to implement and administer said plan. The undersigned hereby certifies that he/she is the duly elected and qualified Secretary and the custodian of the books and records and seal of Company, a legal entity duly formed pursuant to the laws of the State in which it is formed, and that the foregoing is a true record of a resolution duly adopted at a meeting of the Manager(s), and that said meeting was held in accordance with State law and the Bylaws of Company, and that said resolution is now in full force and effect without modification or rescission.

IN WITNESS WHEREOF, I have executed my name as Secretary, Partner, or Managing Member and have hereinto affixed the corporate seal of the above named Corporation (or equivalent for Company if not a corporation) on the date below.

A True Record
Attest.

Authorized Signer

4-9-15
Date

Mayor, City of Sky Valley

Approved by Council 3.31.2015

City of Sky Valley

HEALTHCARE REIMBURSEMENT PLAN

PURPOSE

The Company Healthcare Reimbursement Plan (the "Plan") is adopted by Company effective on the effective date specified in Exhibit 1. The purpose of the Plan is to allow Employees of Company and other Participating Employers to obtain reimbursement of specified Medical Care Expenses on a nontaxable basis from the HRP account. Company intends that the Plan qualify under Code Section 105 and regulations issued thereunder, and shall be interpreted to accomplish that objective. Company intends that the Plan does not qualify as an Eligible Employer-Sponsored Plan (or Minimum Essential Coverage) as defined in Code Section 5000A and regulations issued thereunder and shall be interpreted to accomplish that objective. Furthermore, Company intends that the plan does not provide health insurance coverage or other similar coverage for purposes of satisfying the Individual or Employer Shared Responsibility Payments of the Patient Protection and Affordable Care Act (PPACA), as modified. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from the Participant's income for Federal Income Tax purposes under Code Section 105(b).

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Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Benefits" means the reimbursement benefits for Medical Care Expenses described under Section 4.

"Business Owner" means a sole proprietor, partner, or Two Percent S-Corp shareholder, and/or his spouse.

"C.F.R." means the Code of Federal Regulations.

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

"Claims Processor" means the individual, third party, or other entity designated by the Plan Administrator to receive, substantiate, and recommend whether a claim should be approved for reimbursement or rejected by the Plan Administrator in accordance with Section 4.6.

"Code" means the Internal Revenue Code of 1986 as amended.

"Committee" means the Benefits Committee appointed by the Plan Sponsor.

"Company" means the company or business or partnership named in Exhibit 1 of this Plan.

"Compensation" means earned income, salaries, wages, fees, commissions, and all other earnings paid to the Employee by the Employer.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152(a), with the following exceptions: any child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRP Account will provide benefits in accordance with the applicable requirements of a QMCSO and an adult child as defined in Code Section 152(f) in accordance with PPACA, even if the child does not meet the definition of "Dependent."

"Effective Date" is the effective date listed in Exhibit 1 of this Plan.

"Electronic Protected Health Information" has the meaning described in 45 C.F.R. § 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means an Employee eligible to participate in the Plan, as provided in Section 2.1.

"Eligible Employer-Sponsored Plan" means an Eligible Employer-Sponsored Plan as defined in Code Section 5000A.

"Eligible Medical Expense" means those Medical Care Expenses incurred by the Participant during the Period of Coverage. For purposes of this plan, an expense is "incurred" when the Participant is furnished the medical care or services giving rise to the claimed expense.

"Employee" means any individual that the Employer classifies as a common-law employee and/or who is on the Employer's W-2 payroll who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. The term "Employee" does include "former Employees" and "retired Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 4.8. Additionally, in accordance with IRS Revenue Ruling 71-588and UIL 162.35-02, the "employee-spouse" of a self-employed Employer is considered an Employee for purposes of the Plan provided that the employee-spouse is a bona-fide employee of the Company and must meet the same eligibility requirements of all other Employees within the Employee Class to which the employee-spouse is assigned.

"Employee Class" means a group of one or more employees that are similarly situated with respect to geography, job function, hire date, part-time or full-time status, collective bargaining status, or other objective business criteria. Additionally, an Employee Class may consist of one or more Employees who are similarly situated with respect to having one or more adverse health factors as defined in 29 C.F.R. §2590.702(g).

"Employer" means the Company and any other Related Employer that adopts this Plan with the approval of Company. Related Employers, if any, which have adopted this Plan are listed in Schedule 1 of this Plan.

"Employment Commencement Date" means the first regularly-scheduled working day on which the employee first performs an hour of service for the Employer for compensation.

"Enrollment Form" means the form provided by the Plan Administrator for the purpose of allowing an eligible Employee to participate in this Plan, which may be electronic.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

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

"Health FSA" means a Health Flexible Spending Arrangement.

"Health Insurance Plan" means the plan(s) that Employees and their Spouses and Dependents may be enrolled in, providing major medical type benefits through individual or group health insurance coverage.

"Health Savings Account" or **"HSA"** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

"Highly Compensated Employee" means any Employee defined as such in Section 414(q) of the Code.

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

"HRP" means a healthcare reimbursement plan as defined in Code § 105.

"HRP Account" means the HRP Account described in Section 4.4.

"Key Employee" means any Employee defined as such in Section 416(I) of the Code.

"Manager(s)" means the Sole Proprietor or Partner(s) or Managing Member or Board of Directors that govern the Company.

"Medical Care Expense" means an insurance expense incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code section 213, or as described as Eligible Reimbursable Expenses under Schedule A to this Plan, but shall not include expenses that are described as "excluded expenses" under Schedule B to this Plan. Medical Care Expense includes expenses incurred for basic preventive care services as required by PHS Act 2713.

"Minimum Essential Coverage" means Minimum Essential Coverage as defined in Code Section 5000A.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"Participating Employer" means Company and any Related Employer that adopts this Plan with the consent of the Manager(s).

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate during a Plan Year, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 2.1; and (b) for Employees who terminate participation during a Plan Year, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 2.2. A different Period of Coverage (e.g., monthly) may be established by the Plan Administrator and communicated to Participants.

"Plan" means the Company Healthcare Reimbursement Plan as described herein and in any applicable Adoption Agreement, and which is intended for the exclusive benefit of Eligible Employees, and as may be amended from time to time.

"Plan Administrator" means the Company, who has full authority, discretion, and responsibility to manage and direct the operation and administration of the Plan, or the third party, entity, or

person whom the Company designates to direct one or more elements of such operation and administration.

"Plan Number" or **"PN"** assigned by the Plan Sponsor or its designee, as listed in Exhibit 1 of this Plan.

"Plan Sponsor" means the Company.

"Plan Year" means the plan year period specified in Exhibit 1 of this Plan.

"PPACA" means the Patient Protection and Affordable Care Act (HR 3590) as modified.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Related Employer" means any employer affiliated with Company that, under Code Section 414(B)(c), or (m), is treated as a single employer with Company for purposes of Code Section 105.

"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).

"SPD" means the separate Summary Plan Description describing the terms of this Plan.

"Two Percent S-Corp Shareholder means an individual who owns on any day during the taxable year of the S-Corporation more than 2 percent of the outstanding stock of such corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation, in accordance with Code Section 1372(a).

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Section 2

PARTICIPATION IN THE PLAN

2.1 Commencement of Participation. An individual is eligible to participate in the Plan if the individual is an Employee and meets the eligibility requirements for his or her class of employment as specified in Schedule A of this Plan. The Employee's coverage will commence effective on the date specified by Employer or Plan Administrator after the employee has met the Plan's eligibility requirements and an enrollment form has been submitted to the Plan Administrator.

2.2 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates; or
B. the date on which the employee ceases to be an Eligible Employee; provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis under Section 4.8.

Reimbursements from the HRP Account after termination of participation will be made pursuant to Section 4.7 and 4.8 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA). Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.3 Recommencement of Participation. A former active Participant, who is rehired within 30 days or less of the date of termination of employment, will be reinstated with the same HRP Account balance that such individual had before termination. If an Employee terminates employment and is not rehired within 30 days, or ceases to be an Eligible Employee for any other reason and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 (and Schedule A) before again becoming eligible to participate in the Plan. However, any former active Participant shall

be prohibited from making any enrollment change from his prior enrollment in the Plan Year, except as provided in Section 2.4. Such family status changes must occur while the Employee is a Participant.

2.4 Modification to Benefit Enrollees. Any Participant may make a change to his or her enrollment form after the Plan Year has commenced, to be effective for the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in enrollment is considered if there is a change in status for the Participant's dependents. Any new enrollment form shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the enrollment form is completed and returned to the Plan Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Events that change a Participant's legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;
(2) Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
(3) Dependent satisfies or ceases to satisfy the eligibility requirements due to attainment of age, change in student status, or any similar circumstance;
(4) A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:

2.5 FMLA and USERRA Leaves of Absence. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave" applicable to groups of 50+ employees), or under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave" applicable to any size group), may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA or USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA or USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA or USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA or USERRA leave commences than other Plan Participants.

2.6 Non-FMLA and Non-USERRA Leaves of Absence. A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation, as describe in Section 2.2.

2.7 **Participation of Business Owners.** In accordance with the Code, an employee who is a Business Owner is not eligible to be a Participant in the Plan. However, the Plan Administrator may permit the Business Owner to utilize services of the Claims Processor and/or other entities designated by the Plan Administrator per Section 6.2(G) so that the Business Owner may make premium payments for accident and health insurance, furnish proof of such payments to the Plan Administrator, and then receive reimbursement for such premium payment from the Company in accordance with IRS Notice 2008-1

Additionally, the Plan Administrator may provide the Company and the Business Owner with information required to meet Federal Income Tax requirements, including the requirement that the Company include

the reimbursements for these premiums in the Business Owner's gross income in the year in the reimbursements are received.

Section 3

BENEFITS AND FUNDING OF THE PLAN

3.1 Provision of Benefits. When the Eligible Employee becomes a plan Participant, an HRP Account will be established for the Participant to receive Benefits in the form of reimbursements for Medical Care Expenses as described in this Plan. Under no circumstances shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible Medical Care Expenses. The benefits provided thereunder shall be subject further to the provisions of any plan, contract, or other arrangement setting forth the further terms and conditions of the Benefit Program, and the terms of each Participating Employer's plan, contract or other arrangement, under which benefits provided are incorporated by reference in this Plan.

3.2 Plan Enrollment. An Employee who becomes eligible to participate in the Plan will begin participation after the eligibility requirements of Schedule A have been satisfied, provided that an Enrollment Form is submitted to the Plan Administrator before any benefits are received. Once enrolled, the employee's participation will continue from month-to-month and year-to-year until the employee's participation terminates, pursuant to Section 2.2. The Spouse and any Dependents whose medical expenses may be submitted to the HRP must be identified on the Enrollment Form.

3.3 Employee Contributions. There are no employee contributions for benefits under the Plan.

3.4 Employer Contributions. Employer contributions to the HRP Accounts are notional. However, reimbursements approved by the Plan Administrator are legal obligations of the Employer under the Plan.

3.5 No Funding Under a Cafeteria Plan. The benefits cannot be funded with salary reduction contributions, employer contributions (e.g. flex credits) or otherwise under a cafeteria plan (defined in Section 125 of the Code).

3.6 Funding of the Plan. All of the amounts payable under the Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any participant and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

3.7 Nondiscrimination. Contributions and benefits under the Plan shall not unfairly discriminate, according to applicable sections of the Code. For purposes of applying the eligibility and discrimination provisions of §105(b) (2)-(3) and §105(h) of the Internal Revenue Code, each Employee Class shall be deemed as a separate plan.

Section 4

HEALTHCARE REIMBURSEMENT BENEFITS

4.1 Benefits. The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRP Account, as set forth and adjusted under Section 4.3.

4.2 Eligible Medical Care Expenses. Under the HRP Account, a Participant may receive reimbursement for eligible Medical Care Expenses incurred during a Period of Coverage.

An eligible Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage provided that the Participant was a Participant in the Plan during both Periods of Coverage.

Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through a Health Insurance Plan, other insurance, or any other accident or health plan, (see section 4.11 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (for example, due to health insurance plan co-payment or deductible limitations), the HRP account can be used to reimburse the remaining portion of such Expense if it otherwise meets the requirements of this plan.

It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request reimbursement that may violate the terms of the Participant's insurance policy.

4.3 Maximum Benefits. The maximum allowed benefit is outlined in Schedule A attached to this Plan Document. In future, the maximum dollar limits may be changed by the Plan Administrator and shall be communicated to Employees through the Enrollment Form, the SPD or another document. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Plan Administrator in its sole discretion. Notwithstanding, these maximum benefits may be increased at the sole discretion of the Plan Administrator to comply with Public Health Services Act Section 2711 and 2713.

4.4 Establishment of the HRP Account. The Plan Administrator will establish and maintain an HRP Account with respect to each Participant, but is not required to create a separate fund or otherwise segregate assets for this purpose. The HRP Account so established will merely be a records-keeping account with the purpose of keeping track of contributions and available reimbursement amounts.

A Participant's HRP Account will be credited in accordance with the allowance terms specified in Schedule A.

A Participant's HRP Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRP Account reduced by prior reimbursements debited.

4.5 Carryover of Accounts and Vesting. Any HRP benefit payments that are unclaimed within 90 days after the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred, such as uncashed benefit checks, shall remain the property of the Employer.

Additionally, upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected or the account has vested.

4.6 Substantiation of Expenses. Each Participant must submit a written or electronic Claim Form to the Plan Administrator accompanied by a written statement or bill from an independent third party stating that the expense has been incurred and the amount thereof. The forms shall contain such evidence as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed. Claims must be submitted within the applicable time period specified in Exhibit 1.

4.7 Reimbursement Procedure. Within a period specified in Exhibit 1 of this Plan 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. Reimbursements will generally not be made for claims while the aggregate amount claimed is below the minimum reimbursement specified in Exhibit 1.

4.8 Reimbursements After Termination and COBRA. When a Participant ceases to be a Participant under Section 2.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates unless the Participant's account was fully vested. The Participant, or the Participant's estate, may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant or the Participant's estate files a claim within the specified claim submission period for Terminated Participants in Exhibit 1.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRP account because of a COBRA qualifying event, shall be given the opportunity to continue on a self pay basis, the same coverage that he or she had under the HRP account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA participants. The HRP Account of Qualified Beneficiaries shall be credited in the same manner as similarly situated non-COBRA beneficiaries (provided that the applicable premium is paid). A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and are permitted by COBRA.

4.9 Named Fiduciary. Company named in Exhibit 1 is the named fiduciary for the Plan for purposes of ERISA section 402(a).

4.10 Compliance with ERISA, COBRA, HIPAA, etc. Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

4.11 Coordination of Benefits; Health FSA to Reimburse First. Benefits under this plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expense until after amounts available for reimbursement under the Health FSA have been exhausted.

Section 5

APPEALS PROCEDURE

5.1 Procedure If Benefits Are Denied Under This Plan. In the event a claim is denied ("adverse benefit determination"), Participants will be notified regarding the reason for the denial within thirty (30) days of the receipt of the claim. If within four (4) months from the date of denial, and after discussing the denial with the Plan Administrator, a Participant continues to disagree with the decision, the Participant will have the right to exercise the Appeals Procedure outlined in Section 5.2.

5.2 Appeals Procedure. In order to exercise the right to appeal an adverse benefit determination, a Participant must send a written request to the Plan Administrator. A Participant may also request, free of charge, all relevant documents and records pertaining to his or her claim. As part of the request for Internal Review, a Participant should:

- Cite specific reasons the Participant believes the claim should be approved or partially approved;
- Include any additional documentation that supports the Participant's case;
- Include an explanation of benefits statement if applicable;
- Include and cite specific references to the Plan Document; and
- Include a copy of the denial confirmation.

The necessary information to initiate the Appeals Procedure should be submitted to:

Attn: **City of Sky Valley**
Mandi Cantrell
3444 Highway 246
Dillard, ga, 30537

5.3 Appeals Notification. The Plan Administrator will notify a Participant of its decision on appeal (whether adverse or not) within a reasonable period of time, but not later than forty-five (45) days after it receives an appeal request, unless a Participant agrees to further extend the decision-making period.

5.4 Adverse Benefits Determination on Appeal. If a decision on appeal is adverse, or if Plan coverage is rescinded or terminated for cause, the Plan Administrator will notify Participant in writing or electronically (for example, by e-mail). Any adverse benefit determination, including any denial, reduction, or termination, in whole or in part, of the benefit for which the Participant filed a claim, is a claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was incurred or whether the expense itself is eligible for reimbursement. A notice of adverse benefit determination on appeal will be provided in a culturally and linguistically appropriate manner and will:

- Provide information to help the Participant identify the claim;
- Inform the Participant of the specific reasons for the adverse determination;
- Provide the Participant with a description of the Plan standard, if any, used in denying the claim;
- Inform the Participant of the specific Plan provisions on which the determination was based;
- Provide an explanation of the Plan's internal and external appeal procedures, including applicable time limits;
- Contain a description of any additional information necessary to perfect the claim and an explanation of why this information is necessary;
- Contain a statement that the Participants is entitled to receive, upon request and without charge,

reasonable access to and copies of all documents, records and other relevant information;

- Include a statement of a Participant's right to bring a civil action under ERISA if his or her claim has been denied after he or she has asked for and received a review of the initial denial;
- Reference any internal rule, standard, guideline, protocol, or other similar criterion ("internal criteria") that was relied upon in making an adverse benefit determination, if applicable to the Participant's appeal and include a statement that a copy of the rule, standard, guideline, or protocol may be obtained upon request at no charge;
- Include a statement that the Participant is entitled to receive, upon request and without charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to his or her medical circumstances, if applicable to his or her appeal; and
- Provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in the Participant's state.

Before the Plan can issue an adverse benefit determination on review based on a new or additional reason or "rationale", Participant will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision upon appeal in order to provide the Participant with a reasonable opportunity to respond prior to that date. The Plan Administrator's decision will be considered final and binding on all parties, unless a Participant voluntarily submits the claim to external review, as outlined in Section 5.5.

5.5 External Review. Once a Participant has exhausted the internal appeals procedures described in Section 5.2, the Participant will have the right to request an external review from a non-biased Independent Reviewing Organization ("IRO"). Generally, a Participant will have the right to seek an external appeal unless his or her claim was denied because he or she is not eligible to participate in the Plan. Participants will have up to four months to file an external appeal. Participant will have an opportunity to provide additional materials to the IRO regarding the claim once the external review is initiated. The IRO's decision is binding on the Plan and Participant, except to the extent that other remedies are available under state or federal law. For more information about rights to an external review, Participants can contact the Employee Benefits Security Administration at 866 444-EBSA (3272).

5.6 Legal. All decisions of the Plan Administrator will be final and binding. If a claim is denied in whole or in part, Participants will have the right to file a civil action in court, but the Participant will not be able to do so unless the Participant has completed the appeal procedures described in Section 5. If a Participant does not follow and complete these procedures, an appeal of a claim in court will be subject to dismissal for the Participant's failure to exhaust his or her claim and appeal rights under the Plan. This requirement that a Participant exhaust the Plan's claim filing and appeals procedures applies not only to claims for benefits, but also to claims that the Plan Administrator, Claims Processor, a Plan fiduciary, or Employer has violated ERISA or the Code. If a Participant wishes to file his or her claim in court, he or she must do so within one year of the date on which he or she receives the Appeals Notification. This one year limitation requirement applies to claims for benefits, claims alleging statutory violations of ERISA or the Code, or claims that both seek benefits and allege statutory violations.

Section 6

PLAN ADMINISTRATION

6.1 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that the Plan is carried out, in

accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without unfair discrimination among them.

6.2 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers it considers necessary or appropriate to discharge its duties. It shall 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 shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall 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 enroll in and submit claims 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 shall from time to time determine to be necessary for the proper administration of this Plan;
(E) to furnish each Employee and Participant with reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate;
(F) to receive, review and keep on file such reports and information concerning 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.

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

6.3 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Plan Sponsor, 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 shall remain the obligation of the Plan Sponsor.

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

6.5 Compensation of the Plan Administrator. Unless otherwise determined by the employer and permitted by law, any Plan Administrator who is also an employee of the employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Plan Sponsor.

6.6 Inability to Locate Participant. 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 shall be forfeited following a reasonable time after the date that any such payment first became due.

6.7 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or 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 shall, to the extent that it deems administratively possible and otherwise permissible under code Section 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerate, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRP Account or distributions to which he or she is properly entitled under the Plan.

Section 7

HIPAA PRIVACY AND SECURITY

7.1 Employer's Certification of Compliance
The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 C.F.R. § 164.504(f) (2)(ii), and that Employer agrees to conditions of disclosure set forth in this Section 7.

7.2 Permitted Disclosure of Enrollment/Disenrollment Information
The Plan may disclose to the Employer information on whether the individual is participating in the Plan.

7.3 Permitted Uses and Disclosures of Summary Health Information
The Plan 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 Plan.

"Summary Health Information" means information (1) 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 (2) from which the information described at 42 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

7.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes
Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), 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. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Section 7 (including, but not limited to, the restrictions on Employer's use and disclosure described in

7.5) and the specifications and requirements of HIPAA and its implementing regulations at 45 C.F.R. Parts 160-64.

7.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to the Protected Health Information or Electronic Protected Health Information, respectively.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(e) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

7.6 Adequate Separation Between Employer and the Plan

(a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:

- Privacy Official;
- Employees in the Employer's Human Resources Department;
- Employees in the Employer's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

(b) The employees, classes of employees or other workforce members identified in Section 7.6(a), above, will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 7.5, above.
(c) The employees, classes of employees or other workforce members identified in Section 7.6(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Section 7.

7.7 Security Measures for Electronic Protected Health Information
The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Covered Individual's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

7.8 Notification of Security Incident
The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

Section 8

MISCELLANEOUS PROVISIONS

8.1 Expenses. All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

8.2 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

8.3 Amendment and Termination. The Employer reserves the right to amend or terminate all or any part of this Plan at any time for any reason without notice, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan. Any such amendment or termination shall be effective as of such date as the Employer shall determine. In the case of amendment or termination of the Plan, the Employer must reimburse all claims with dates of service prior to the date of amendment or termination that are approved by the Plan Administrator in accordance with terms of the Plan.

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

8.5 Applicable Laws. This Plan shall be construed, administered and enforced according to the applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

8.6 Code and ERISA Compliance. It is intended that this Plan meet all applicable requirements of the IRS Code and ERISA, and of all regulations issued thereunder. This Plan shall 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 and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

8.7 Plan is Not Minimum Essential Coverage. This Plan is not an Eligible Employer-Sponsored Plan (or Minimum Essential Coverage) as defined in Code Section 5000A. If this Plan is ever interpreted to be an Eligible Employer Sponsored Plan (or Minimum Essential Coverage), the Participant can, at his or her sole discretion, retroactively terminate his or her participation in the Plan to a prior date of their choosing, and any reimbursements he or she has received during the period since the prior date will be considered taxable income. Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

8.8 Tax Consequences. Neither the Employer nor the Plan Administrator makes any warranty or guarantee that any amounts paid to or for the benefit of any Participant under this Plan will be treated as excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the responsibility 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. Under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employee as a result thereof.

8.9 Indemnification of the Employer. If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements. The Participant shall indemnify and reimburse the Employer for any liability it may incur related to any refund of tax credits received by the Participant.

8.10 Non-Assignability of Rights. The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall 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 such extent as may be required by law.

8.11 Plan Provision Controlling. In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument are in any construction interpreted as being in conflict with the provisions of the Plans as set forth in this document, the provisions of this Plan shall be controlling.

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

Schedule A, Full Time

SCHEDULE OF ELIGIBILITY, BENEFITS, AND PLAN PROVISIONS

Eligibility Requirements	
Employee Class	Full Time
Date of Eligibility	Participants are eligible to participate in the HRP no earlier than their date of hire and no later than the first day of the next calendar month after their date of hire once they meet the eligibility requirements below.
Minimum Hours Per Week	30.00
Waiting Period (days)	30 Days, including the date on which employment commences.
Require Health Insurance Coverage	Health insurance coverage that qualifies as Minimum Essential Coverage is required for eligibility.

HRP Allowances	
	Allowances
Employee Only	$700.00/month
Employee & Spouse	$700.00/month
Employee & Child(ren)	$700.00/month
Employee & Family	$700.00/month

Other Plan Provisions	
Administrative Fees	Paid by employer
Maximum Benefit	Maximum Benefit For the Plan Year, the maximum benefit is equal to the annualized value of Participant's HRP Allowances.
Eligible Reimbursable Expenses	Health Insurance Expenses are reimbursable if they meet the definition of "medical care" as it relates to insurance under the Internal Revenue Code Section 213 and may otherwise be reimbursable under IRS guidance, except as noted in Schedule B. See IRS Publication 502 for additional information on reimbursable health insurance expenses permitted by the Internal Revenue Code. Participants may not submit expenses that have already been reimbursed by, or will be reimbursed by, any other insurance or health benefit plan. Participants are responsible to ensure that medical expenses for which they request reimbursement are eligible for reimbursement under the terms and conditions of the health insurance, HRP, and/or other health benefit plans under which they and/or their eligible dependents are covered. Participants are allowed to submit employer-sponsored health insurance claims for reimbursement.

Exhibit 1

DESCRIPTION OF THE City of Sky Valley HEALTHCARE REIMBURSEMENT PLAN

Plan Information	
Company Name	City of Sky Valley
State of Legal Domicile	Georgia
HRP Effective Date	02/01/2015
Plan Name	City of Sky Valley Healthcare Reimbursement Plan
Plan Number	502
Privacy Official	Mandi Cantrell
Plan Year	The twelve-month period commencing each January 1 and ending on the subsequent December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is changed, in which case the Plan Year shall be the entire short plan year.

Timing For Submitting and Receiving Reimbursements	
Active Employees	Claims and documentation must be submitted within 180 days of the date of service However, claims and documentation for dates of service in prior Plan Year must be submitted within 90 days of the close of prior Plan Year
Terminated employees	Claims and documentation must be submitted within 90 days from the date of termination. Only claims with dates of service up to and including the date of termination may be eligible for reimbursement.
Timeframe for reimbursements	The Plan Administrator must reimburse approved claims within 90 days of the date claims are approved by the Plan Administrator, provided sufficient funds exist in the Participant HRP Account.
Minimum Reimbursement	Reimbursement may not be made for approved claims until the aggregate amount to be reimbursed exceeds $10.00, except for the final reimbursement claim for a Period of Coverage.