



MEMO

To: Board of Directors
Gary O'Connell, Executive Director

From: Lisa L. Breeden, Finance Director

CC: James M. Bowling, IV

Date: August 8, 2010

Re: Flexible Benefits Plan Amendments

The Treasury Department and the Internal Revenue Service have announced changes to the following provision of Sections 105 and 125 of the *Internal Revenue Code of 1954 (as amended)*:

- Effective with plan years beginning on or after January 1, 2011, over-the-counter medications will no longer qualify for reimbursement. This change is reflected in the following definition listed on page 4 of our *Flexible Benefits Plan* and, upon approval, will be implemented with the new plan year beginning September 1, 2010:
 - "Medical Care" includes the diagnosis, cure, mitigation, treatment, or prevention of sickness, injury, or defect. Expenses for Medical Care shall consist of expenses for medical care as defined in Sections 213 (d) (1) and (e) of the Code, and shall include, but not be limited to, payments for the purpose of affecting any structure or function of the body, for any hospital or nursing charges, optometric, ophthalmologic, or auditory care, dental care, psychiatric care, prescription drugs, insulin, eyeglasses, hearing aid appliances, and similar prosthetic devices, medical related transportation expenses, and medical insurance premiums.

In order to implement this change, our current Flexible Benefits Plan must be amended. Attached for your consideration is an updated, draft version of our current Flexible Benefits Plan. (The proposed change is highlighted in this copy.)

Flexible Benefits Plan

Effective 09/01/1987

Last Amended: 08/18/2005

Last Amended: 07/16/2009

Last Amended: 08/19/2010

ALBEMARLE COUNTY SERVICE AUTHORITY

Flexible Benefits Plan

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The Plan

Section 1.1 - Establishment

The Albemarle County Service Authority (hereafter "Authority") hereby establishes, effective as of September 1, 1987, a plan of flexible compensation for the benefit of eligible employees, which shall be known as Albemarle County Service Authority Flexible Benefits Plan (the plan).

Section 1.2 - Purpose

The purpose of the Plan is to provide benefits that suit the needs of eligible employees by allowing them to choose, with moneys provided as specified herein, among different combinations of insurance coverage, medical care benefit coverage, dependent care coverage, and direct cash compensation. The Plan is intended to comply with the provisions of Sections [105](#), [106](#), [125](#), and [129](#) of the Internal Revenue Code of 1954, as amended.

Definitions

Section 2.1 - Definitions

Whenever used in the Plan, the following words and phrases shall have the meaning set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized:

- 1) "Code" means the Internal Revenue Code of 1954, as amended. References to a Code section shall be deemed to be to that section as it now exists and to any successor provision.
- 2) "Compensation" of a Participant means the total salary, wages, bonuses, pay for overtime, vacation pay, sick pay, pay for shift differentials, Voluntary Early Retirement benefits, and other cash compensation paid by the Authority to a Participant (without regard to any salary reduction under this Plan), but excluding reimbursed expenses, credits or benefits under any plan or deferred compensation to which the Authority contributes, and any additional compensation payable in a form other than cash.
- 3) "Dependent" means an individual who qualifies as a dependent under the terms of Section [152](#) of the code.
- 4) "Effective Date" means the date on which the Plan became effective, i.e., September 1, 1987.
- 5) "Employee" means an employee of the Authority who is a full or part time employee as defined in the Authority Personnel Management System, or a former employee of the Authority who is an active participant in the Voluntary Early Retirement Incentive Plan as defined in the Authority Personnel Management System"
- 6) "Employment Related Dependent Care Expenses" means the amount paid for expenses of a Participant for household services or for the care of a Qualifying Individual, to the extent that such expenses are incurred to enable the Participant

to be gainfully employed for any period for which there are one (1) or more Qualifying Individuals with respect to such Participant: provided, however, that

- a) if such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Individual who is a Dependent under the age of thirteen (13) whom the Participant is entitled to an exemption under Section 151(e) of the Code or for a Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant's household; and
 - b) if the expense is incurred outside the Participant's home at a facility that provides care for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
 - c) that Employment Related Dependent Care Expenses of a Participant shall not include expenses paid or incurred for services provided by
 - i) a child of such Participant who is under the age of nineteen (19) for
 - ii) an individual who is a Dependent of such Participant or Participant's spouse.
- 7) "Exempted Injury or Sickness" means any injury or sickness:
- a) Incurred when a Participant was engaged in, or resulting from a Participant having engaged in, a criminal enterprise; or
 - b) Resulting from an intentionally self-inflicted injury of a Participant.
- 8) "Grace Period" means an extension of the current Plan Year not to exceed 2 and ½ months. The effect of the Grace Period is that the Participant may have as long as 14 months plus 15 days (September 1 – August 31 - November 15) to incur qualified expenses.
- 9) "Injury" means an externally caused sudden hurt or damage to the body brought about by an identifiable event.
- 10) "Medical Care" includes the diagnosis, cure, mitigation, treatment, or prevention of sickness, injury, or defect. Expenses for Medical Care shall consist of expenses for medical care as defined in Sections 213 (d) (1) and (e) of the Code, and shall include, but not be limited to, payments for the purpose of affecting any structure or function of the body, for any hospital or nursing charges, optometric,

ophthalmologic, or auditory care, dental care, psychiatric care, prescription drugs, insulin, eyeglasses, hearing aid appliances, and similar prosthetic devices, medical related transportation expenses, and medical insurance premiums.

Deleted: [over-the-counter drugs \(excluding toiletries, cosmetics, and dietary supplements\)](#).

- 11) "Participant" means a person who is an Employee or a Former Employee as defined in Item 5 on or after the Effective Date and who satisfies the participation conditions of Article 3. A person who becomes a Participant shall remain a Participant until all benefits due him under the provisions of the Plan have been paid to him or otherwise have been settled.
- 12) "Period of Coverage" with respect to any Plan Year, means that Plan Year; provided that, for any Employee who becomes a Participant after the start of a Plan Year, the Period of Coverage shall mean the period commencing on the effective date of such Participant's participation and extending through the remainder of the Plan Year.
- 13) "Plan" means "Authority Flexible Benefits Plan" as set forth herein and as amended or restated from time to time.
- 14) "Plan Year" means the twelve month period ending August 31.
- 15) "Qualifying Individual" means
 - a) a Dependent of a Participant who is under the age of thirteen (13), with respect to whom the Participant is entitled to an exemption under Section 151(e) of the Code, and
 - b) a Dependent or spouse of a Participant who is physically or mentally incapable of caring for himself.
- 16) "Sickness" means all bodily infirmities, diseases, mental illnesses, and other disorders other than an injury.

Section 2.2 – Gender and Number

Except as otherwise indicated by context, masculine terminology used herein also includes the feminine and neuter, and terms used in the singular may also include the plural.

Participation Conditions

Section 3.1 – Participation Conditions

As a condition of receipt of benefits under this plan, the Participant agrees to:

- 1) Furnish the Authority the Application to Participate provided for in Section 3.3 below;
- 2) Observe all Plan rules and regulations;
- 3) Consent to reasonable inquiries by the Authority with respect to any physician, hospital, or other provider of Medical Care or other services involved in a claim under this plan;
- 4) Submit to the Authority all reports, bills, and other information which the Authority may reasonably require; and
- 5) Designate a portion of his Compensation as Pay Conversion Contributions in accordance with the provisions of Article 4.

Section 3.2 – Application to Participate

As a condition of participation, each Employee who is eligible to be a Participant shall execute and deliver to the Authority prior to his/her first day of participation, a written application, signed by him in which he applies to participate in the Plan, designates the required portion of his/her Compensation for the Plan Year in question as Pay Conversion Contributions as described in Article 4, makes a benefit election and supplies any other pertinent information that the Authority reasonably requires.

Section 3.3 – Commencement of Participation

Eligible employees may become Participants only on the first day of a Plan Year; provided that persons becoming eligible Employees on or after the first day of a Plan Year may become participants on the first day of the month following eligibility.

Section 3.4 – Special Enrollment/Revocation Period

Employees and their dependents may become Participants without having to wait for an open enrollment period if either of the following conditions is met: 1) The employee or dependent loses eligibility under CHIP (Children's Health Insurance Program) or Medicaid for individuals who otherwise meet the eligibility requirements of a group health plan; 2) The employee or dependent becomes eligible for premium assistance from the State under its CHIP or Medicaid program, if otherwise eligible for a group health plan. Enrollment must be requested within 60 days after the loss of eligibility under Medicaid or CHIP or after the date the employee or dependent is determined eligible for premium assistance.

Pay Conversion and Benefit Elections

Section 4.1 – Pay Conversion

Each Participant shall designate a portion of his Compensation for each Plan Year as Pay Conversion Contributions. Except as otherwise provided by the Authority, Pay Conversion Contributions shall reduce the Participant's Compensation ratably on each pay day during the Plan Year following the effective date of the Participant's Participation.

Section 4.2 – Benefit Elections

Each Participant shall make a benefit election, in the manner provided herein, to apply his Pay Conversion Contributions during each Plan Year, in such proportions as he chooses, to the following:

- 1) to pay the Participant's premiums for Albemarle County Service Authority sponsored insurance as set forth in Article 5;
- 2) to increase the Participant's Medical Care Reimbursement Account for that Plan Year in accordance with Article 6;
- 3) to increase the Participant's Dependent Care Reimbursement Account for that Plan Year in accordance with Article 7.

A Participant's initial benefit election shall be made as part of his Application to Participate. Thereafter a Participant may change his/her benefit election for a subsequent Plan Year by providing written notice thereof to the Authority at least ten (10) days prior to the first day of the Plan Year for which such change is to be effective. A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except for the automatic adjustment provided in Article 5, except for the special enrollment and/or revocation periods provided in Article 3.4, and except

that in the event there is a change in a Participant's marital status or number of Dependents or there is a termination of employment of the Participant's spouse, a Participant shall be entitled to change his benefit election in a manner that is consistent with such change in marital, Dependent or employment status, by providing written notice thereof to the Authority, in a form acceptable to the Authority. Any such change shall be effective on the first day of the first calendar month in which such change occurs.



Insurance Benefits

Section 5.1 – Insurance Benefits

To the extent a Participant so elects, a portion of the Participant's Pay Conversion Contributions shall be used to pay the Participant's share of the cost of coverage under any existing Authority sponsored Life, Health, Medical, Dental, or Hospitalization insurance or other similar health and accident plan for Employees. If there is a change in the cost of a particular type of coverage selected by a Participant, the Participant's election shall automatically be adjusted to reflect such change. A Participant, however, will not be permitted to change coverage during a Plan Year because of a change in the cost of coverage.

Medical Reimbursement Plan

Section 6.1 – Medical Care Reimbursement Accounts

The Authority shall establish for each Participant a Medical Care Reimbursement Account for each Plan Year. Each Medical Care Reimbursement Account shall initially contain zero dollars (\$0.00).

Section 6.2 – Increase in Medical Care Reimbursement Accounts

A Participant's Medical Care Reimbursement Account for a Plan Year shall be increased by the portion of the Participant's Pay Conversion Contributions for that Plan Year that he has elected to apply toward his Medical Care Reimbursement Account pursuant to Section 4.2.

Section 6.3 – Decrease in Medical Care Reimbursement Accounts

A Participant's Medical Care Reimbursement Account for a Plan Year shall be reduced by the amount of any benefits paid to or on behalf of a Participant pursuant to Section 6.4.

Section 6.4 – Medical Care Benefits

Subject to limitations contained in other provisions of this Plan, a Participant who incurs expenses for Medical Care attributable to himself, his spouse, or his dependents during his Period of Coverage for a Plan Year plus the Grace Period shall be entitled to receive from the Authority full reimbursement for the entire amount of such expenses to the extent of the amount contained in the Participant's Medical Care Reimbursement Account for that Plan Year. The Authority shall pay all such expenses to the Participant upon the presentation to the Authority of documentation of such expenses in a form satisfactory to the Authority. In its discretion, the

Authority may pay any of such expenses directly, in which event the Authority shall be relieved of all further responsibility with respect to that particular expense.

Participants shall be reimbursed for such expenses on a monthly or other more frequent basis determined by the Authority; provided that the final payment of benefits for any Plan Year shall be made by the tenth day of the 2nd month following the close of the Plan Year plus the Grace Period based on accepted claims filed with the Authority by the last day of the preceding month.

If a Participant ceases to be an Employee, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of the amount remaining in the Participant's Medical Care Reimbursement Account for the Plan Year of the termination of his employment.

Upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Section 6.5 or from any other source.

Section 6.5 – Limitations on Medical Care Benefits

Anything herein to the contrary notwithstanding, no benefits shall be paid under this Article 6:

- 1) In the event and to the extent that such reimbursement or payment is covered under any insurance policy or policies, whether paid for the Authority or the Participant, or under any other health or accident plan by whoever maintained. In the event that there is such a policy or plan in effect providing for such reimbursement or payment, in whole or in part, then to the extent of the coverage under such policy or plan, the Authority shall be relieved of any liability hereunder.
- 2) To the extent that an expense has been submitted for reimbursement from a Participant's Dependent Care Reimbursement Account.
- 3) Due to Exempted Injury or Sickness.

Section 6.6 – Forfeiture of Unused Benefits

If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage for any Plan Year plus the Grace Period, any amount remains in a Participant's Medical Care Reimbursement Account for that Plan Year, the Participant shall forfeit such amount to the Authority for use as provided in Article 8, and shall have no further claim thereto.

Section 6.7 – Separate Written Plan

For purposes of the Code, this Article 6 shall constitute a separate written plan providing for the reimbursement of Medical Care expenses. To the extent necessary other provisions of the Plan are incorporated by reference in this Article 6.

Dependent Care Assistance Plan

Section 7.1 – Dependent Care Reimbursement Accounts

The Authority shall establish for each Participant a Dependent Care Reimbursement Account for each Plan Year. Each Dependent Care Reimbursement Account shall initially contain zero dollars (\$0.00).

Section 7.2 – Increases in Dependent Care Reimbursement Account

A Participant's Dependent Care Reimbursement Account for a Plan Year shall be increased by the portion of the Participant's Pay Conversion Contributions for that Plan Year that he has elected to apply toward his Dependent Care Reimbursement Account pursuant to Section. 4.2.

Section 7.3 – Decrease in Dependent Care Reimbursement Account

A Participant's Dependent Care Reimbursement Account for a Plan Year shall be reduced by the amount of any benefits paid to or on behalf of a Participant pursuant to Section 7.4.

Section 7.4 – Dependent Care Benefits

Subject to limitations contained in other provisions of this Plan, a Participant who incurs Employment Related Dependent Care Expenses during his Period of Coverage for a Plan Year plus the Grace Period shall be entitled to receive from the Authority full reimbursement for the entire amount of such expense to the extent of the amount contained in the Participant's Dependent Care Reimbursement Account for that Plan Year; provided that no reimbursement shall be paid pursuant to this Article

7 to the extent an expense has been submitted for reimbursement from a Participant's Medical Care Reimbursement Account. The authority shall pay all such expenses to the Participant upon presentation to the Authority of documentation of such expense in a form satisfactory to the Authority. However, in its discretion, the Authority may pay any of such expenses directly, in which events the Authority shall be relieved of all further responsibility with respect to that particular expense. Participants shall be reimbursed for such expenses on a monthly or other more frequent basis determined by the Authority; provided that the final payment of benefits for any Plan Year shall be made by the tenth day of the 2nd month following the close of the Plan Year plus the Grace Period based on accepted claims filed with the Authority by the last day of the preceding month.

If a Participant ceases to be an Employee, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of the amount remaining in the Participant's Dependent Care Reimbursement Account for the Plan Year of the termination of his employment.

Section 7.5 – Forfeiture of Unused Benefits

If, following the final payment of reimbursement benefits for eligible expenses incurred during the Period of Coverage for any Plan Year plus the Grace Period, any amount remains in a Participant's Dependent Care Reimbursement Account for that Plan Year, the Participant shall forfeit such amount to the Authority for use as provided in Article 8, and shall have no further claim thereto.

Section 7.6 – Annual Statement of Benefits

On or before the end of the 3rd month following the Plan Year, the Authority shall furnish to each individual who was a participant that received benefits under Section 7.4 during the prior Plan Year, a statement of all such benefits paid to or on behalf of such Participant during the prior Plan Year.

Section 7.7 – Separate Written Plan

For purposes of the Code, this Article 7 shall constitute a separate written plan providing a program of dependent care assistance. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 7.

Use of Forfeitures

Section 8.1 – Use of Forfeitures

An account shall be established on the Authority books called the Forfeitures Account, which shall initially contain zero dollars (\$0.00). After the completion of benefit payments under Sections 6.4 and 7.4 for each Plan year, the amounts of all forfeitures in Sections 6.6 and 7.6 shall be determined and added to the Forfeitures Account. At any time that the amount in the Forfeitures Account exceeds the product of Ten Dollars (\$10.00) multiplied by the number of Participants who are the Employees, the Authority shall pay a cash bonus to each such Participant in an amount equal to the highest whole dollar amount that may be paid to each such Participant without exhausting the Forfeitures Account, which bonuses shall reduce the balance in the Forfeitures Account. In such instances the bonus paid to each Participant shall be the same and no bonus received by any Participant shall be based on or be dependent upon the amount of such Participant's forfeitures, if any, under Sections 6.6 or 7.6. In the event of a Plan termination, following payment of all remaining reimbursements and final forfeitures, pro-rata portion of the balance of the Forfeitures Accounts shall be paid as a bonus to each Participant who is then an employee.

Claims Procedure

Section 9.1 – Claims Procedures

The Authority shall notify a Participant in writing within ninety (90) days of his written application for benefits of his eligibility or non-eligibility for benefits under the Plan. If the Authority determines that a Participant is not eligible for benefits or full benefits, the notice shall set forth

- 1) The specific reason for such denial;
- 2) A specific reference to the provision of the Plan on which the denial is based;
- 3) A description of any additional information or material necessary for the claimant to perfect his claim, and a description of why it is needed; and
- 4) An explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have his claim reviewed.

If the Authority determines that there are special circumstances requiring additional time to make a decision, the Authority shall notify the Participant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional ninety-day (90) period. If a Participant is determined by the Authority to be not eligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, he shall have the opportunity to have his claim reviewed with the Authority within sixty (60) days after receipt by him of the notice issued by the Authority. Said petition shall state the specific reasons the Participant believes he is entitled to benefits or greater or different benefits. Within sixty (60) days after receipt by the Authority of said petition, the Authority shall afford the Participant (and his counsel, if any) an opportunity to present his position to the Authority orally or in writing, and said Participant (or his counsel) shall have the right to review the pertinent documents. The Authority shall notify the Participant of its decision in writing within said sixty (60) day period, stating specifically the basis of said decision written in a manner

calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based. If, because of the need for a hearing, the sixty (60) day period is not sufficient, the decision may be deferred for up to another sixty (60) day period at the election of the Authority, but notice of this deferral shall be given to the Participant, the same procedure shall be applicable to his beneficiaries.



Administration and Finances

Section 10.1 – Administration

The Plan shall be administered by the Authority. The Authority shall bear all administrative costs of the Plan.

Section 10.2 – Powers of the Authority

The Authority shall have all powers necessary to administer the Plan, including, without limitation, powers:

- 1) to interpret the provisions of the Plan;
- 2) to establish and revise the method of accounting for the Plan and to maintain the accounts, and
- 3) to establish rules for the administration of the Plan and to prescribe any forms required to administer the Plan.

Section 10.3 – Actions of the Authority

All determinations, interpretations, rules and decisions of the Authority shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Section 10.4 – Delegation

The Authority shall have the power to delegate specific duties and responsibilities to officers or other employees of the Authority or other individuals or entities. Any delegation by the Authority may allow further delegations by the individual or entity to which the delegation is made. Any delegation may be rescinded by the Authority at any time. Each person or entity to which a duty or responsibility has been delegated shall be responsible for the exercise of such duty or responsibility and shall not be responsible for any act or failure to act of any person or entity.

Section 10.5 – Reports and Records

The Authority and those to whom the Authority as delegated duties under the Plan shall keep records of all their proceedings and actions and shall maintain books of accounts, records, and other data as shall be necessary for the proper administration of the Plan and for compliance with applicable law.

Section 10.6 – Finance

The costs of the Plan shall be borne as provided herein. For purposes of this Plan, Pay Conversion Contributions shall be deemed contributions by the Authority.

Amendments and Termination

Section 11.1 – Amendments

The Authority may amend the Plan, in full or in part, at any time and from time to time. Any such amendment shall be filed with the Plan documents.

Section 11.2 – Benefits Provided Through Third Parties

In the case of any benefit provided pursuant to an insurance policy or other contract with a third party, the Authority may amend the Plan by changing insurers, policies, or contracts without changing the language of this Plan document, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are informed as to the effects of any such changes.

Section 11.3 – Termination

The Authority expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time. In the event of a Plan termination, Pay Conversion Contributions will cease. Thereafter neither the Authority nor any of its employees shall have any further financial obligations hereunder except such that have accrued up to the date of termination and have not been settled.

Miscellaneous

Section 12.1 – No Guaranty of Employment

The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Authority and any Employee. Nothing contained herein shall give any Employee the right to be retained in the employ of the Authority or to interfere with the right of the Authority to discharge any Employee at any time, nor shall it give the Authority the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

Section 12.2 – Limitation on Liability

The Authority does not guarantee benefits payable under any policy or contract of insurance described herein, and any benefits payable hereunder shall be the exclusive responsibility of the insurer that issued such contract or policy.

Section 12.3 – Non-Alienation

No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Section 12.4 – Applicable Law

The Plan and all rights hereunder shall be governed by and construed according to the laws of the Commonwealth of Virginia, except to the extent such laws are preempted by the laws of the United States of America.

Section 12.5 – Benefits Provided Through Third Parties

In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with such third party, if there is any

conflict or inconsistency between the description of benefits contained in this Plan and such contract or policy, the terms of such contract or policy shall control.