



Staff Report

Date: August 2, 2016

To: City Council

From: Valerie J. Barone, City Manager

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Subject: **Considering adoption of an Amended Flexible Spending Account Section 125 Program to Provide for a Cafeteria Plan Option, and Establishing a Health Reimbursement Arrangement Account.**

Report in Brief

As a result of the negotiation outcomes with all employee bargaining groups, the City Council adopted changes relating to medical coverage for active employees, as well as significant reforms to the retiree medical program, including limiting the employer contribution to retiree medical for new employees to the minimum rate established annually by the California Public Employees' Retirement System (CalPERS) for the Public Employees' Medical and Hospital Care Act (PEMHCA).

CalPERS requires that all agencies participating in PEMHCA adopt resolutions fixing the employer contribution, and that all employees and retirees be treated equally in terms of the retiree medical benefit. As a result, at its meeting of September 13, 2016, Council will be considering the adoption of PEMHCA resolutions for all its employee groups setting the employer contribution for 2017 to the PEMHCA minimum (\$128 per month). However, as Council has further adopted and vested a higher employer contribution benefit for active employees and current retirees, in order to ensure that active employees and current retirees receive the appropriate vested employer contribution, the City must now amend its existing Flexible Spending Account (FSA) Section 125 plan to provide for a cafeteria plan option as a mechanism for providing active employees with the difference between the PEMHCA minimum and the negotiated employer contribution for active employee medical on a tax-exempt basis. Further, for retiree medical, to ensure retirees (and eligible active employees when they retire) are "made whole" and receive the vested employer contribution amount for retiree medical, the City must also establish a Health Reimbursement Arrangement

account (HRA) to provide a mechanism for providing eligible retirees with the difference between the PEMHCA minimum and the vested employer contribution for retiree medical.

By amending the City's existing FSA plan to provide for a cafeteria plan option, along with establishing a new HRA, the City sets the appropriate funding/payment mechanisms in place to comply with labor contract provisions, commitments made to current employees and retirees regarding the vested level of employer contribution for retiree medical, and remains in compliance with CalPERS regulations.

Recommended Action

Staff recommends the City Council authorize and adopt an amended Flexible Spending Account Section 125 plan to allow for a cafeteria plan provision, enabling the City to comply with MOU provisions for employee medical premium benefits on a tax-exempt basis; and further authorize the establishment of a new Health Reimbursement Arrangement account, providing the mechanism for reimbursement for all current retirees for fixed and vested employer contributions to retiree medical at the levels established per Resolution No.16-57, which was adopted by the City Council at its meeting of August 2, 2016; all consistent with the plan documents attached hereto. Staff recommends the City Council authorize the City Manager to sign the plan documents.

Background

As a result of contract negotiations which occurred in 1998, the City currently provides medical benefits for active employees and retirees through the CalPERS health system. The City's contribution to active employees' medical premiums is determined through negotiations with the respective employee groups. During the course of recently completed labor negotiations, the City Council reformed the retiree medical benefit for all bargaining units, resulting in cost savings and a significant reduction of future liability for the program (estimated to be \$16 Million).

CalPERS requires participating agencies to submit a resolution fixing the employer contribution. The reformed retiree medical benefit provides for an employer contribution for new employees equal to PEMHCA minimum as established by CalPERS annually, the City is required to submit a resolution to that effect. The resolution will be considered by the Council for all employee groups in a separate action at its meeting of September 13, 2016. Upon Council authorization, the PEMHCA minimum would take effect for January 1, 2017 forward, and would, per CalPERS requirements, be applied to all employees (both current and new) and existing retirees.

However, through new MOU provisions and associated resolutions, the City Council has also fixed and vested employer contribution amounts for active employee medical and

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retiree medical higher than PEMHCA minimum for existing employees within bargaining as follows:

Council Meeting Date:	Employee Group:	Resolution Nos.:
June 28, 2016	International Brotherhood of Teamsters Union Local 856	16-4735.3
July 12, 2016	Office and Professional Employees International Union (OEPIU), Local 29	16-4735.7
August 2, 2016	Concord Police Association	16-4735.11
August 2, 2016	Concord Police Managers' Representation Unit	16-4735.10

Council established the same retiree medical reforms for Unrepresented employees, which include Confidential Employees, Managers, and Executive Management (including the City Manager and the City Attorney) via Resolution Nos. 16-4735.8, 16-4735.9, and 16-4735.10 respectively. Further, on August 2, 2016, the Council vested the same reformed employer contribution for retiree medical for existing Unrepresented employees per Resolution No. 16-67, and vested the reformed benefit for all existing retirees (regardless of former employee/bargaining group) via Resolution No.16-57.

The retirement medical reforms result in changes to the process in which the City pays its employer contribution for medical premium for active employees. To retain tax exempt status for the difference between the PEMHCA minimum and the higher employer contribution negotiated with all bargaining unit, the City must amend its existing Flexible Spending Account (FSA) Section 125 plan to provide for a cafeteria plan option. The reforms also impact the method in which the City provides the vested employer contribution amount for retiree medical for current retirees, requiring the establishment of a Health Reimbursement Arrangement (HRA) as a means for reimbursing retirees for the difference between the PEMHCA minimum and the vested employer contribution for medical premiums.

Analysis

Through recently completed labor negotiations, the City Council instituted significant reforms to the retiree medical program which will result in significant cost savings and reduces the future liability of the retiree medical program. The reformed benefit levels differ for current employees and existing retirees, as compared to new employees. As a

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result, there are two benefit levels available: a higher employer contribution level (based on reformed 2016 employer contribution fixed rates) for current employees and retirees, and a second, lower tier of benefit for new employees (at the PEMHCA minimum as established annually by CalPERS).

CalPERS requires participating agencies to submit resolutions fixing the employer contribution for PEMHCA, and further requires agencies to provide the same base benefit employer contribution level for active employees and retirees for medical insurance. As the Council has now established a lower retiree health employer insurance contribution level for new employees when they retire (if eligible for the benefit) at the PEMHCA minimum, the City must submit a resolution to CalPERS at the PEMHCA minimum for all.. Consequently, program changes are necessary to meet the City's higher employer insurance contribution level for both active employees and for eligible existing retirees and current employees when they retire. Each group is discussed below.

Active Employee Medical: For active employees, the benefit level provides for 90% of the 2016 Kaiser premium for Basic (pre-Medicare) plans, with the City and employees sharing any increases or decreases in premium for 2017 on a 75% City/ 25% employee formula. Prior to the reform, the City would pay CalPERS directly for the entire portion of the employer contribution on a tax exempt basis. Effective January 1, 2017, with the change in benefit reflecting the lower tier of benefit at the PEMHCA minimum (\$128/month for 2017), the City must amend its existing Flexible Spending Account (FSA) Section 125 plan to provide for a new cafeteria plan option. By utilizing the cafeteria plan option, the City is able to retain the tax exempt status of the employer contribution amounts remaining between the \$128 PEHMCA minimum and the higher benefit negotiated with all employee bargaining groups. Absent the addition of the cafeteria plan, the City would lose its ability to retain the tax exempt status for those funds.

Retiree Medical: Currently, the City pays CalPERS the full employer contribution, with CalPERS deducting from the retiree's pension payment the retiree's share for retiree medical premium. However, effective January 1, 2017, as a result of the requirement to reduce the employer contribution to PEMHCA minimum, CalPERS will only invoice the City for the PEMHCA minimum of \$128 per month, and deduct the remaining amount (the difference between the 2017 premium and the \$128 PEMHCA minimum) from the retiree's pension payment.

To ensure current retirees are "made whole" and are provided with the higher (vested) employer contribution level, the City must establish a Health Reimbursement Arrangement (HRA) account as a vehicle for reimbursing the retiree for the difference

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between the PEMHCA minimum and the vested employer contribution. An HRA will enable the City to direct a third-party administrator to issue reimbursement payments to retirees, timed to coincide with the receipt of the retiree's CalPERS pension on the first of the month. In this manner, the retiree's net contribution to retiree medical will be balanced. The amount of employer contribution they receive shall remain the same, but the method in which they will receive the benefit will be changing. While the CalPERS pension check will reflect a higher deduction for retirement medical premium, the retiree will concurrently receive a reimbursement check through the HRA, making them whole.

Financial Impact

There is no fiscal impact resulting from amending the FSA plan to include a cafeteria plan option. The cost for establishing and maintaining an HRA plan to reimburse retirees is approximately \$21,000 annually, consisting of third party administrator services. There are sufficient funds in the Human Resources departmental budget for FY 16/17 to cover this cost.

Public Contact

The City Council Agenda was posted, and the respective representatives for the City's bargaining groups were notified.

Attachments

1. FSA Section 125 Plan (amended to include a cafeteria plan option)
2. HRA plan document

**REIMBURSEMENT ACCOUNT (FSA/DCAP/TRANSIT)
FLEXIBLE BENEFITS PLAN
AND ALL SUPPORTING FORMS HAVE BEEN PRODUCED FOR
City of Concord**

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**REIMBURSEMENT ACCOUNT (FSA/DCAP/TRANSIT)
FLEXIBLE BENEFITS PLAN**

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**REIMBURSEMENT ACCOUNT (FSA/DCAP/TRANSIT)
FLEXIBLE BENEFITS PLAN**

INTRODUCTION

The Employer has amended this Plan effective 2016, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on 2010. The Plan shall be known as Reimbursement Account (FSA/DCAP/Transit) Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

**ARTICLE I
DEFINITIONS**

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit" or "Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means 2010.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual employed as a regular full-time employee in accordance with the employment practices and policies of the Employer is an "Eligible Employee". That is, such individual is reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means City of Concord and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"Employer Contribution"** means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V and as set forth in Section 3.1.

1.14 **"Grace Period"** means, with respect to any Plan Year, the 75 day period after the end of such Plan Year, during which Medical Expenses and Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year.

1.15 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.16 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.17 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.18 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.19 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.20 **"Plan"** means this instrument, including all amendments thereto.

1.21 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.22 **"Premium Expenses" or "Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.23 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.24 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.25 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.26 **"Spouse"** means "spouse" as defined in an Insurance Contract for purposes of coverage under that Contract only or the "spouse," as defined under Federal law, of a Participant, unless legally separated by court decree.

1.27 **"Incapacitated"** means incapable of self-care "if as a result of physical or mental defect [he or she] is incapable of caring for [his or her] hygiene or nutritional needs, or requires full-time attention of another person for [his or her] own safety or the safety of others. Code §21(b)(1)(C) requires that a spouse who is physically or mentally incapable of self-care also have "the same principal place of abode as the taxpayer for more than one-half of [the] year."

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Employee, as defined in Section 1.10, shall be eligible to participate in the Plan while employed in a regular full-time capacity by the Employer.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;
- (b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or
- (c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.
- (b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.
- (c) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

CAFETERIA PLAN

The Employer shall make available to each Participant enrolled in a Public Employee's Medical and Hospital Care Act (PEMHCA) medical plan an Employer Contribution in an amount to be determined by the Employer prior to the beginning of each Plan Year. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available for the exclusive purchase of Health Insurance Benefits. The Employer's Contribution shall be made on a pro rata basis for each pay period of the Participant. The Employer Contribution is defined as follows:

- (a) **Minimum Employer Contribution** – Effective January 1, 2017, the Employer shall make a direct contribution equal to the minimum employer contribution for agencies participating in the Public Employees Medical and Hospital Care Act (PEMHCA) on behalf of each Participant.
- (b) **Premium Contribution** – The Employer shall make a premium contribution on behalf of each Participant in an amount which, together with the minimum PEMHCA contribution, as defined in the above section, equals the

Employer's contribution amounts identified per applicable Memoranda of Understanding or Resolution. Beginning in 2017, and through the term of existing Memoranda of Understanding, the Employer contribution is calculated based on the Employer/Employee cost share on annual premium changes, where the Employer shares 75% and the Employee shares 25% for any future increases or decreases in the Kaiser Premium. For 2017, the Employer Contribution equals the following amounts:

- i. Participant Only - \$662.01
- ii. Participant + One Dependent - \$1,324.03
- iii. Participant + Two or More Dependents - \$1,721.23

In subsequent plan years, these amounts will vary due to fluctuations to the Kaiser Premium and the Employer/Employee cost share set at 75% and 25%, respectively.

(c) **No Cash Out** – If the Participant fails to make an election of Health Insurance Benefits and/or provides proof of enrollment in other group medical insurance, the Participant is not eligible to receive the Employer Contribution as cash.

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

- (1) Health Flexible Spending Account
- (2) Dependent Care Flexible Spending Account
- (3) Insurance Premium Payment Plan
 - (i) Health Insurance Benefit
 - (ii) Dental Insurance Benefit

- (iii) Group-Term Life Insurance Benefit
- (iv) Vision Insurance Benefit
- (v) Accidental Death and Dismemberment Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

- (a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
- (b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.
- (c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 GROUP-TERM LIFE INSURANCE BENEFIT

- (a) **Coverage for Participant only.** Each Participant may elect to be covered under the Employer's group-term life Insurance Contract.
- (b) **Employer selects contracts.** The Employer may select suitable group-term life Insurance Contracts for use in providing this group-term life insurance benefit, which policies will provide benefits for all Participants electing this Benefit on a uniform basis.
- (c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group-term life Insurance Contract shall be determined therefrom, and such group-term life Insurance Contract shall be incorporated herein by reference.

4.7 VISION INSURANCE BENEFIT

- (a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.
- (b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.
- (c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.8 ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

- (a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's accidental death and dismemberment Insurance Contract.
- (b) **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment policies for use in providing this accidental death and dismemberment insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.
- (c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract shall be determined therefrom, and such accidental death and dismemberment Insurance Contract shall be incorporated herein by reference.

4.9 NONDISCRIMINATION REQUIREMENTS

- (a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- (b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- (c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

**ARTICLE V
PARTICIPANT ELECTIONS**

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- (a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- (b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;
- (c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Solely with respect to the Health Flexible Spending Account and Dependent Care Flexible Spending Account, any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS OR QUALIFYING EVENTS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to 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 the 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 election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the 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) **Legal Marital Status:** events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
- (2) **Number of Dependents:** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- (3) **Employment Status:** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes 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; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's

or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

(l) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage (as defined in Code § 5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

- (1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's employment status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and
- (2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) 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 Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- (2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals 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 original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

- (1) one of the 5 highest paid officers;
- (2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
- (3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is \$2550.

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(c) **Grace Period.** Payment of expenses from a previous year in the first months of the next Plan Year, the limit above applies to the Plan Year including the Grace Period. Amounts carried into the next Plan Year as part of the Grace Period shall not affect the limit for that next Plan Year.

(d) **Untimely Claims.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105

who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year including the Grace Period shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Grace Period.** Notwithstanding anything in this Section to the contrary, Medical Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates.

(e) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

- (1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any periods for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) 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 Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 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

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

- (d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,
 - (1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;
 - (2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
 - (3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

(b) **Untimely Claims.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year including the Grace Period and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;
- (c) The relationship, if any, of the person performing the services to the Participant;
- (d) If the services are being performed by a child of the Participant, the age of the child;
- (e) A statement as to where the services were performed;
- (f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- (g) If the services were being performed in a day care center, a statement:
 - (1) that the day care center complies with all applicable laws and regulations of the state of residence,
 - (2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
 - (3) of the amount of fee paid to the provider.
- (h) If the Participant is married, a statement containing the following:
 - (1) the Spouse's salary or wages if he or she is employed, or
 - (2) if the Participant's Spouse is not employed, that
 - (i) he or she is incapacitated, or
 - (ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.
- (i) **Grace Period.** Notwithstanding anything in this Section to the contrary, Employment-Related Dependent Care Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates.
- (j) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

7.13 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

- (a) **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.
- (b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Dependent Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.
- (c) **Only available for use with certain service providers.** The cards shall only be accepted by such service providers as have been approved by the Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers.
- (d) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.
- (e) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as an Employment-Related Dependent Care Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
 - (1) Repayment of the improper amount by the Participant;
 - (2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
 - (3) Claims substitution or offset of future claims until the amount is repaid; and
 - (4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VIII BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

- (a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.
- (b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:
 - (1) specific references to the pertinent Plan provisions on which the denial is based;
 - (2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
 - (3) an explanation of the Plan's claim procedure.
- (c) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:
 - (1) request a review upon written notice to the Administrator;

- (2) review pertinent documents; and
- (3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if applicable) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal in writing (or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

- (a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving or working within his or her scope of employment as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as 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 Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith, without actual malice and in the apparent best interests of the Employer .

ARTICLE X AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

**ARTICLE XI
MISCELLANEOUS**

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

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

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or 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 the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Federal Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" (or "PHI") shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

- (i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- (ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- (iii) mitigation of any harm caused by the breach, to the extent practicable; and
- (iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

- (1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- (a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of _____.

City of Concord (Employer)

By _____
City Manager

Recommended by: _____
Director, Human Resources

Approved as to form:

City Attorney

**CITY OF CONCORD
INSURANCE PREMIUM REIMBURSEMENT PLAN**

FOR RETIREES

ARTICLE I: INTRODUCTION

1.1 *Self-insured Medical Expense Reimbursement Plan Status.* This Plan is intended to qualify as a "self-insured medical expense reimbursement plan" as defined at Section 105(h) of the Internal Revenue Code.

1.2 *Purpose of Plan.* The purpose of this Plan is to reimburse certain former employees for certain medical expenses incurred by those former employees.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 **"Administrator"** means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.3 **"Effective Date"** means January 1, 2017.

2.4 **"Eligible Expense"** means an expense that qualifies for reimbursement under this Plan, as described in Article IV.

2.5 **"Eligible Person"** means a former employee of the Employer who has satisfied one of the applicable requirements below:

Retirees who retired PRIOR to the implementation of retiree medical reforms:

- 1. At the time you became a Retiree, you retired directly from the City of Concord and were otherwise eligible for the pre-reform retirement medical benefit.

AND

- 2. You are enrolled for coverage in one of the Employer’s CalPERS PEMHCA medical insurance plans for Retirees.

OR

For retirees who retired AFTER implementation of retiree medical reforms:

- 1. At the time you became a Retiree, you were a member of one of the following units with the Employer:
 - i. Administrative, Technical & Clerical Representation Unit (ATC)
 - ii. Field & Operations Representation Unit (F&O)
 - iii. Unrepresented Employees and Elected Officials, to include Council-appointed Employees, Executive Management, Mid-Management, Confidential and Full-time Contracted Employees (Unrepresented)
 - iv. Office and Professional Employees (Professionals)
 - v. Concord Police Association Unit (POA)
 - vi. Concord Police Managers’ Representation Unit (PMA)

AND

2. You started working for the Employer or received a conditional offer of employment with the Employer *prior* to the applicable effective date:
 - i. Administrative, Technical & Clerical Representation Unit – June 28th, 2016
 - ii. Field & Operations Representation Unit – June 28th, 2016
 - iii. Unrepresented Employees and Elected Officials, to include Council-appointed Employees, Executive Management, Mid-Management, Confidential and Full-time Contracted Employees – June 28th, 2016
 - iv. Office and Professional Employees – July 12th, 2016
 - v. Concord Police Association Unit – August 2nd, 2016
 - vi. Concord Police Managers' Representation Unit – August 2nd, 2016

AND

3. Before you became a Retiree of the City of Concord, you met the vesting requirements for City of Concord service as applicable:
 - i. Completed five (5) or more years of continuous service with the City of Concord as a member of one of the following units:
 - a) Administrative, Technical & Clerical Representation Unit (ATC)
 - b) Field & Operations Representation Unit (F&O)
 - c) Unrepresented Employees and Elected Officials, to include Council-appointed Employees, Executive Management, Mid-Management, Confidential and Full-time Contracted Employees (Unrepresented)
 - d) Office and Professional Employees (Professionals)

OR

- ii. Completed ten (10) or more years of continuous sworn service with the City of Concord as a member of one of the following units:
 - a) Concord Police Association Unit (POA)
 - b) Concord Police Managers' Representation Unit (PMA)
4. You retired directly from the City of Concord, in accordance with CalPERS and PEMHCA requirements; and
 5. You are enrolled for coverage in one of the CalPERS PEMHCA medical insurance plans for Retirees.

2.6 **"Employer"** shall mean the City of Concord.

2.7 **"Participant"** means any Eligible Person whose Participant Commencement Date has occurred.

2.8 **"Participation Commencement Date"** means the date on which an Eligible Person becomes a Participant, which is the date on which he or she first becomes an Eligible Person.

2.9 **"Plan"** means the City of Concord Insurance Premium Reimbursement Plan for Retirees as set

forth herein, together with any and all amendments and supplements hereto.

- 2.10 **"Plan Year"** means the period used to maintain the books and records of the Plan, which shall be the twelve-month period beginning on January 1 and ending on the following December 31.
- 2.11 **"Retiree"** means a former eligible employee of the City of Concord who retired directly from the City, and met the service vesting and other eligibility requirements for CalPERS retirement and PEMHCA medical participation as approved by the Concord City Council via resolutions and/or MOU provisions.

ARTICLE III: PARTICIPATION

- 3.1 *Becoming a Participant.* Each Participant may begin to incur Eligible Expenses on his or her Participation Commencement Date.

ARTICLE IV: BENEFITS

- 4.1 *Eligible Expenses.* Subject to the limitations set forth below, the Plan shall reimburse a Participant for a portion of the cost of his or her Eligible Expenses. For purposes of the Plan, "Eligible Expense" means the difference between the PEMHCA minimum (which the City of Concord pays directly to CalPERS on the Participant's behalf) and the fixed, vested amount of employer contribution to which the Participant is entitled, based on the amounts listed in Council Resolution Nos. 16-4735.3, 16-4735.7, 16-4735.10, 16-4735.11, 16-57, and 16-67.

- 4.2 *Maximum Reimbursement Amount.* The maximum amount of reimbursement to which a Participant shall be entitled for Eligible Expenses incurred during the same Plan Year shall be determined in accordance with the terms of any provision in a collective bargaining agreement that specifies such maximum. The maximum amounts are fixed as specified in Council Resolution Nos. 16-4735.3, 16-4735.7, 16-4735.10, 16-4735.11, 16-57, and 16-67. The City Council vested the fixed, higher employer contributions for retiree medical for current retirees and eligible current employees at 90% of the 2016 Kaiser rate for Basic (pre-Medicare) plans, and at the existing 2016 employer contribution rate (without change) for Medicare and Combination plans.

The monthly reimbursement amounts are calculated based on the level of coverage, years of service with the Employer and type of health plan in which you are enrolled.

Table 1 is applicable to the following eligible retirees:

1. **ALL RETIREES** (Sworn and Non-Sworn) who were retired **prior** to the Retiree Medical Reforms, and
2. **ALL NON-SWORN** retirees that retire with at least five (5) years of more of continuous service with the Employer and were actively employed by the Employer prior to the date of implementation of Retiree Medical Reforms (June 28th, 2016 – ATC, F&O, and Unrepresented; July 12th, 2016 – Professionals)

Table 1		Pre-Medicare	Medicare		
Level of Coverage	Basic Plan Type	Supplemental Plan Type	Combination Plan Type Option 1 (Retiree is Medicare eligible, but dependent(s) may not)	Combination Plan Type Option 2 (Retiree is not Medicare eligible, but one or more dependent(s) are)	
Retiree Only	\$671.82	\$287.52	\$937.30	\$937.30	
Retiree+1	\$1,343.65	\$575.04	\$1,321.01	\$1,235.10	
Retiree+2 or more	\$1,746.74	\$862.56	\$974.16	\$1,321.01	

Table 2 is applicable **For ALL SWORN** retirees (POA and PMA) that were actively employed by the Employer prior to the date of implementation of Retiree Medical Reforms (August 2nd, 2016) in accordance with the following vesting schedule:

Table 2		Pre-Medicare	Medicare		
Years of Sworn Service with Employer	Level of Coverage	Basic Plan Type	Supplemental Plan Type	Combination Plan Type Option 1 (Retiree is Medicare eligible, but dependent(s) may not)	Combination Plan Type Option 2 (Retiree is not Medicare eligible, but one or more dependent(s) are)
10 – 14 years	Retiree Only	\$671.82	\$287.52	\$937.30	\$937.30
	Retiree+1	\$1,343.65	\$575.04	\$1,321.01	\$1,235.10
15+ years	Retiree+2 or more	\$1,746.74	\$862.56	\$974.16	\$1,321.01

ARTICLE V: ADMINISTRATION OF PLAN

5.1 *Plan Administrator.* The Plan Administrator shall administer the Plan in accordance with its terms without discriminating among the Participants. The Plan Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

5.2 *Examination of Records.* The Plan Administrator shall make available to each Participant such of his or her records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

5.3 *Reliance on Tables, etc.* In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator.

5.4. *Indemnification.* Plan Administrator agrees to defend, indemnify and hold harmless the CITY, its officers, officials, employees, agents and volunteers from and against any and all claims, demands, actions, losses, damages, injuries, and liability (including all attorney's fees and other litigation expenses) arising out of the Plan Administrator's performance under the terms of this Agreement. This indemnification obligation on Plan Administrator's part shall not apply to demands, actions, losses, damages, injuries, and liability arising out of sole negligence or willful misconduct on the part of CITY.

ARTICLE VI: REIMBURSEMENT PROCESS

6.1 *Reimbursement Process.* The Plan Administrator has retained P&A Administrative Services, Inc. of Buffalo, New York to provide the reimbursement of Eligible Expenses on its behalf.

6.2 *Appeals Procedure.* If a claim for reimbursement is denied in whole or in part, the appeals procedures described in the Plan Summary for this Plan shall apply.

6.3 *Scope of Claims Review under this Plan.* Any claim for benefits under any health insurance plan of the Employer shall be governed by the claims procedures that are included in the plan documents pursuant to which that plan is maintained. The claims procedures in this Article shall apply only to (i) any partial or total denial of benefits under this Plan, and (ii) any denial of benefits due to an issue germane to the claimant's eligibility under the Plan.

ARTICLE VII: AMENDMENT AND TERMINATION OF PLAN

The Plan may at any time be amended or terminated an action of the governing body of the Employer provided such action does not violate the terms of any collective bargaining agreement.

ARTICLE VIII: MISCELLANEOUS PROVISIONS

8.1 *Information to be Furnished.* Participants shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

8.2 *Limitation of Rights.* Neither the establishment of the Plan nor any amendment thereof, nor the

payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Plan Administrator, except as provided herein.

8.3 *Benefits Solely From General Assets.* Except as may otherwise be required by law:

(a) Nothing herein will be construed to require any fund or segregated amount to be maintained for the benefit of any Participant; and

(b) 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 the Plan may be made.

8.4 *Use and Disclosure of Protected Health Information.*

(a) Members of the Employer's workforce have access to the individually identifiable health information of Participants for Plan administrative functions. When this information is provided by the Plan to the Employer, it is "protected health information" ("PHI"). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following definition of PHI applies for purposes of this Section 8.4:

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

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

(b) The Plan may disclose to the Employer whether a particular individual is a Participant.

(c) The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests it for the purpose of modifying, amending or terminating the Plan. For this purpose, "Summary Health Information" means information (a) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan, and (b) from which the information described in 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(d) Unless otherwise permitted by law, and subject to the conditions of disclosure described in (e) below, and obtaining written certification in accordance with (g) below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses It only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. The term does not include functions performed by the Employer in connection with any other benefit plan or any employment-related functions.

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

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

- (1) not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- (2) ensure that any agent, including a subcontractor, to whom the Employer provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- (3) not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- (4) report to the Plan any unauthorized use or disclosure of PHI that it becomes aware of;
- (5) make PHI available to comply with HIPAA's rights to access in accordance with 45 CFR section 164.524;
- (6) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR section 164.526;
- (7) make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528;
- (8) make its internal practices, books and records relating to the use and disclosure of HIPAA received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- (9) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which it disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- (10) ensure that the adequate separation between the Plan and the Employer (the "firewall") required by 45 CFR section 504(f)(2)(iii) is maintained.

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

(f) The Employer shall allow the following persons access to PHI: the Director of Human Resources, Senior HR Analyst and HR Analyst II and any other Employee who needs access to PHI to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll and appeals). No other persons shall have access to PHI.

These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's disciplinary and termination procedures.

The Employer shall ensure that the provisions of this (f) are supported by reasonable and appropriate security measures.

(g) The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan incorporates the provisions of 45 CFR section 504(f)(2)(ii) and that the Employer agrees to the conditions of disclosure set forth in (e) above.

8.5 *Governing Law.* This Plan shall be construed, administered and enforced according to the laws of the State wherein the principal office or place of business of the Employer is located.

8.6 *Complete Document.* This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Employer document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions, and the remainder of the Plan document shall continue in full force and effect.

IN WITNESS WHEREOF, the Employer has adopted this Plan as of the Effective Date. In signing below, the Employer hereby certifies that the Plan incorporates the provisions of 45 CFR section 164.504(f)(2)(ii) as set forth in Section 8.4(e) above and agrees to the limitations on the disclosure of PHI described therein.

CITY OF CONCORD

By: _____

Title: _____