(R-2012-554)

RESOLUTION NUMBER R- 307412

DATE OF FINAL PASSAGE MAY 16 2012

A RESOLUTION OF THE COUNCIL OF THE CITY OF SAN DIEGO, PURSUANT TO SECTION 14 OF THE FISCAL YEAR 2013 SALARY ORDINANCE, ESTABLISHING AND ADOPTING A CAFETERIA BENEFITS PLAN FOR ALL DESIGNATED ELIGIBLE EMPLOYEES FOR FISCAL YEAR 2013.

WHEREAS, pursuant to San Diego Ordinance O- 20163 (NEW SERIES), adopted on MAY 1 2012, the Council of the City of San Diego (City Council) formally adopted a Salary Ordinance for Fiscal Year 2013; and

WHEREAS, section 14 of that Ordinance provides that additional benefit programs may be established upon recommendation of the Mayor; and

WHEREAS, the City Council has previously established the City of San Diego Flexible Benefits Plan (Plan), effective October 1, 1984, with terms of the Plan negotiated year-to-year with represented employees, pursuant to the Meyers-Milias-Brown Act; and

WHEREAS, the purpose of the Plan is to provide eligible employees a choice between certain taxable and nontaxable benefits offered under the Plan; and

WHEREAS, the Plan is intended to qualify as a cafeteria plan under section 125 of the Internal Revenue Code and is to be interpreted in a manner consistent with the requirements of that section as it may be amended from time to time; and

WHEREAS, the City Council desires to adopt the Plan for Fiscal Year 2013, effective as of July 1, 2011; NOW THEREFORE,

BE IT RESOLVED, pursuant to section 14 of the Fiscal Year 2013 Salary Ordinance, that the City Council adopts the Flexible Benefits Plan, which is Attachment A to this Resolution, for all designated eligible employees for Fiscal Year 2013.

BE IT FURTHER RESOLVED, that the allotments for flexible benefits for eligible employees under the Plan for Fiscal Year 2013 are adopted as set forth in Attachment B to this Resolution; the amounts set forth in Attachment B reflect the total allotment for each eligible employee.

BE IT FURTHER RESOLVED, that the Mayor is authorized to execute agreements with the appropriate organizations providing the benefits designated in the Plan.

BE IT FURTHER RESOLVED, that the funds appropriated for this Plan are as set forth in the annual appropriation ordinance.

APPROVED: JAN I. GOLDSMITH, City Attorney

By _____
Roxanne Story Parks
Deputy City Attorney

RSP:ccm
04/24/2012
Or.Dept:Human Resources
347872.doc

I hereby certify that the following Resolution was passed by the Council of the City of San Diego at its meeting of MAY - 1 2012.

ELIZABETH S. MALAND
City Clerk

By _____
Deputy City Clerk

Approved: 5.16.12
(date)

_____
JERRY SANDERS, Mayor

Vetoed: _____
(date)

_____
JERRY SANDERS, Mayor

# CITY OF SAN DIEGO

# FLEXIBLE BENEFITS PLAN

**Amended and Restated as of**
**July 1, 2012**

**ATTACHMENT A**

**City of San Diego Flexible Benefits Plan**

**Table of Contents**



**ATTACHMENT A**

# INTRODUCTION

The City of San Diego (the "Plan Sponsor") previously established the City of San Diego Flexible Benefits Plan (hereinafter referred to as "Plan"). The purpose of the Plan is to provide eligible employees a choice between certain taxable and nontaxable benefits offered under this and other plans maintained by the Plan Sponsor. The Plan Sponsor now amends and restates the Plan in its entirety, effective as of July 1, 2012.

The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986 and is to be interpreted in a manner consistent with the requirements of that section as it may be amended from time to time.

## ARTICLE I

## Definitions

Definitions. As used herein, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context. Words in the masculine gender shall be deemed to include the feminine gender, and words in the feminine gender shall be deemed to include the masculine gender; and unless the context otherwise requires, the singular shall include the plural and the plural the singular. Any headings herein are included for reference only and are not to be construed so as to alter any of the terms of the Plan.

1.01 "Benefit Option" means a qualified benefit under Code Section 125(f) that is offered under a Component Plan, including any separate options for coverage under an underlying accident or health plan.

1.02 "Change in Status" means any of the following events:

A. An event that changes an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

B. An event that changes the number of an Eligible Employee's dependents eligible for coverage under a Component Plan, including birth, adoption, placement for adoption (as defined in regulations under Section 9801 of the Code), or death of a dependent;

C. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent:

1. A termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence or a change in worksite, or

2. Any other change in employment status that affects an individual's eligibility for benefits under a plan;

D. An event that causes an Employee's dependent to satisfy or cease to satisfy the definition of Eligible Dependent as set out in the relevant Component Plan; or

E. A change in the place or residence or work of the employee, spouse or dependent.

1.03 "City Council" means the City of San Diego legislative body City Council.

1.04 "Claims Administrator" means a third party designated by the Plan Administrator to determine claims for benefits under the Plan, or in the absence of such designation, the Plan Administrator.

1.05 "COBRA" means the extension of health coverage that must be offered in accordance with Section 2208 of the Public Health Service Act, along with any amendments to such law and any pertinent regulations, rulings, notices or other guidance.

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

1.07 "Compensation" means the total cash remuneration (including payments for vacation, sick pay and short-term disability but not long-term disability) received by the Participant from an Employer during a Plan Year, prior to any reductions pursuant to any Salary Reduction Agreement or under any other Employer-sponsored plan hereunder.

1.08 "Component Plan" means the following plans/programs maintained by the Employer:

A. A welfare benefit plan maintained by the Employer, including the plan providing reimbursement of eligible health care expenses described in Article V; and

B. The plan providing dependent care benefits as described in Article VI.

All Component Plans are maintained in accordance with and are described in Articles V and VI of this document or in one or more documents that are not contained within this plan document. A list of Component Plans is set out in Appendix A.

1.09 "Contribution Pay Period" means a pay period in which Salary Reduction Contributions are taken from a Participant's paycheck.

1.10 "Dependent" means an individual who is eligible for coverage as a dependent of an Eligible Employee as set out in the plan document of the relevant Component Plan, including a domestic partner of an Eligible Employee who has satisfied all conditions for eligibility and who qualifies as the Eligible Employee's tax dependent under the Code. "Dependent" shall also mean an individual whose expenses are eligible for reimbursement under a Participant's Health Care Spending Account or Dependent Care Spending Account as set out Article V or Article VI of this Plan.

1.11 "Dependent Care Spending Account" or "DCSA" means the Component Plan described in Article VI.

1.12 "Election Change" means the revocation of an Employee's election and making of a new election for the remaining portion of the Plan Year.

1.13 "Election Form" means the enrollment form or other enrollment process (including telephonic or electronic enrollment) authorized by the Plan Administrator through which an Eligible Employee makes his benefits election and by which the Eligible Employee agrees to make Salary Reduction Contributions in order to obtain certain benefits.

1.14 "Election Period" means the period designated by the Plan Administrator immediately preceding the beginning of each Plan Year during which the Employee must complete his Election Form.

1.15 "Eligibility Date" means the date the Employee becomes eligible for benefits. Such date is the later of the first day of the first pay period in which the Employee works 40 hours or more as an Eligible Employee, or the date the Employee begins working in benefit status as an Eligible Employee.

1.16 "Eligible Employee" means an Employee who is regularly scheduled to work at least forty (40) hours per payroll period and who is otherwise eligible to participate in one or more of the Component Plans. "Eligible Employee" shall not include an hourly Employee.

1.17 "Employee" means any person currently employed by an Employer who is receiving Compensation for services performed. "Employee" shall not include any person classified in the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or in any other classification other than employee, regardless of any determination by a governmental agency or court that any such person is a common law employee of an Employer.

1.18 "Employee After-Tax Contributions" means those contributions, as described in Section 4.03, that are made by a Participant on an after-tax basis to purchase coverage offered under one or more Component Plans.

1.19 "Employer" means the Plan Sponsor.

1.20 "FMLA Leave" means an approved leave of absence protected by the Family and Medical Leave Act of 1993 as it may be amended from time to time.

1.21 "Health Care Spending Account" or "HCSA" means the Component Plan as described in Article V.

1.22 "Health Plan" means any of the health plans providing medical, dental and/or vision care, including any plan offering benefits through a health maintenance organization, that is offered by the Employer and which is a Component Plan.

1.23 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as it may be amended from time to time.

1.24 "Military Leave" means a leave of absence protected by the Uniformed Services Employment and Reemployment Rights Act of 1994.

1.25 "Non-elective Employer Contributions" means those contributions as described in Section 4.02 of the Plan.

1.26 "Participant" means an Eligible Employee covered under this Plan.

1.27 "Plan" means this City of San Diego Section 125 Plan.

1.28 "Plan Administrator" means the Plan Sponsor or any person appointed by the Plan Sponsor to administer the Plan as set forth in Article X.

1.29 "Plan Sponsor" means The City of San Diego.

1.30 "Plan Year" means the 12-month period beginning each July 1st and ending on the next following June 30th.

1.31 "PHSA" means the Public Health Service Act as amended from time to time. Reference to any section of subsection of the PHSA includes references to any comparable or successor provisions of any law that amends, supplements or replaces such section or subsection

1.32 "Salary Reduction Contributions" means those contributions as described in Section 4.01 of the Plan.

1.33 "Similar Coverage" means coverage under the same type of Benefit Option for the same individuals.

1.34 "Spouse" means the legal spouse of a Participant as recognized under federal law.

1.35 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 as it may be amended from time to time.

## ARTICLE II

## Participation

2.01 Effective Date of Participation

An Eligible Employee will become a Participant in this Plan on his Eligibility Date.

2.02 Termination of Participation

A Participant shall cease to be a Participant on the occurrence of earliest of the following events:

A. The date this Plan terminates.

B. The date the individual ceases to be an Eligible Employee, or

C. The date participation in the Plan is discontinued by the Plan Sponsor.

2.03 Termination of Benefit Option Coverage

Coverage under any Benefit Option elected under this Plan shall terminate on the earlier of:

A. The date so specified in the plan document of the Component Plan or in Articles V, VI or IX of this Plan.

B. The end of each Plan Year.

Coverage for subsequent Plan Years can only be obtained in accordance with the election procedures set forth in Section 3.03.

Notwithstanding the above, a former Participant or other qualified beneficiary, as defined in Section 2208 (3) of the PHSA, or a former Participant who is on a Military Leave may elect to continue coverage under a Component Plan which is a Health Plan beyond the date such coverage would otherwise terminate. The terms and conditions of such continued coverage are set out in the Component Plan's plan document. Contributions to maintain continuation of coverage shall be made directly to the Plan Administrator or insurance carrier as applicable and shall not be made under this Plan, except as otherwise provided under Sections 3.07E.1.

## ARTICLE III

## Election of Benefits

3.01 Benefit Elections

Subject to all other provisions of this Plan, a Participant may choose between receiving his or her full Compensation and receiving coverage under one or more of the Benefit Options provided under the Component Plans set out in Appendix A. Enrollment in any of the Component Plans offered under this Plan shall be governed by the terms, conditions and provisions of that Component Plan's plan document.

3.02 Election Procedures Upon Initial Eligibility

The Plan Administrator shall provide an individual who has become an Eligible Employee with an Election Form or other enrollment capability, on which such Eligible Employee shall elect the Benefit Options in which he or she desires to enroll for the Plan Year and agree to make Salary Reduction Contributions as provided in Article IV. In order for such election to be effective, the Eligible Employee must enroll no more than 31 days after his or her Eligibility Date. If a timely election is made, coverage under the Benefit Options elected will begin on the Eligible Employee's Eligibility Date.

Notwithstanding the above, if a Component Plan provides for mandatory participation or for automatic enrollment in a Benefit Option the absence of an election by the Eligible Employee, such Eligible Employee shall be deemed to have elected coverage under such Benefit Option and to have consented to any applicable Salary Reduction Contributions.

3.03 Annual Enrollment Procedures

Prior to the commencement of each Plan Year, the Plan Administrator shall require each Eligible Employee to elect the Benefit Options in which he or she desires to enroll for the Plan Year and agree to make Salary Reduction Contributions as provided in Article IV. Elections shall be effective as of the first day of the Plan Year. Each election must be completed in accordance with all Plan rules on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period of the Plan Year to which such election applies.

Notwithstanding the above, if a Component Plan provides for mandatory participation or for automatic enrollment in a Benefit Option the absence of an election by the Eligible Employee, such Eligible Employee shall be deemed to have elected coverage under such Benefit Option and to have consented to any applicable Salary Reduction Contributions.

3.04 Failure to Complete Election Process

A. Except to the extent that a Component Plan provides for mandatory participation or automatic enrollment, an Eligible Employee who fails to complete the election process within 31 days of his or her Eligibility Date shall be deemed to have elected to receive his full Compensation in cash and to have elected no nontaxable Benefit Option.

B. A Participant who fails to complete the election process for any subsequent Plan Year shall be deemed to have: (1) elected to continue whatever Benefit Options that he had elected most recently on file with the Plan Administrator; and (2) agreed to have his Compensation reduced by whatever amount is then necessary to purchase such Benefit Options as provided in accordance with Article IV of this Plan.

C. At the discretion of the Plan Administrator, in the event that a Benefit Option in which a Participant had been enrolled is eliminated for the subsequent Plan Year, the Participant will be enrolled in a Benefit Option providing Similar Coverage, if available, as designated by the Plan Administrator. All similarly-situated Participants shall be enrolled in the same Benefit Option.

3.05 Duration of Elections

Except as provided in Section 3.07, a Participant's election is irrevocable and shall remain in effect through the last day of the Plan Year, subject further to the conditions set forth in the plan document of the respective Component Plan.

3.06 Reduction or Revocation of Certain Elections by Plan Administrator

The Plan Administrator may revoke or reduce a Participant's election of Elective Employer Contributions and Non-elective Employer Contributions under this Plan at any time prior to or during a Plan Year, to the extent necessary to prevent this Plan from being considered discriminatory under Sections 79, 125(b), 105(h)(2) or 129(d)(2) of the Code.

A. In the case that such reduction affects health benefits, only the elections of Participant(s) who are highly compensated as defined in either Section 105(h) or Section 125(e) of the Code may be reduced.

B. In the case that such reduction affects other qualified benefits, only the elections of Participants who are highly compensated as defined in Section 125(e) of the Code or are otherwise key employees as defined in Section 125(b) of the Code may be reduced.

C. In the case that such reduction affects dependent care assistance benefits under Section 129 of the Code, only the elections of Participants who are officers,

owners or highly compensated individuals as defined in Section 129(d) of the Code or their dependents may be reduced.

3.07 Changes in Employee Elections

A. Special Enrollment Rights. A Participant who is entitled to special enrollment rights under a Component Plan as required by Sections 2704(f) (1) and (2) of the PHSA may make an Election Change with respect to such Component Plan, provided the Participant enrolls himself or herself and/or his or her spouse and dependents under a Health Plan Benefit Option that is a group health plan: (1) in the case of special enrollment rights arising from the acquisition of a new dependent child through birth, adoption or placement for adoption, within 60 days of such birth, adoption or placement for adoption or (2) in all other instances, within 31 days of the occurrence of the event giving rise to such special enrollment rights.

An Eligible Employee who has special enrollment rights under a group health plan as provided under Section 2704(f)(3) of the PHSA may make an Election Change with respect to such group health plan coverage provided the Eligible Employee enrolls himself or herself and/or his or her spouse and dependents under a Health Plan Benefit Option that is a group health plan subject to the requirements of HIPAA within 60 days after: (1) the date the Eligible Employee's or his or her spouse's or dependent's Medicaid or state children's health insurance program ("CHIP") coverage terminates or (2) the date the Eligible Employee or his or her spouse or dependent is determined to be eligible for a Medicaid or CHIP premium-assistance subsidy for qualified employer-sponsored health coverage.

B. Changes in Status

1. A Participant may make an Election Change with respect to the various Benefit Options offered under this Plan if such Election Change:

a. is on account of and is consistent with a Change in Status that affects eligibility for coverage under an employer's plan or coverage under a particular benefit package option under such plan. For this purpose, a Change in Status that results in the increase or decrease in the number of a Participant's family members who may benefit from coverage under the plan or option shall be deemed to affect eligibility for coverage. A Participant may make an Election Change with respect to the DCSA Benefit Option only if such Election Change is on account of and is consistent with a Change in Status event that affects expenses described in Section 129 of the Code (including employment-related expenses as defined in Section 21(b)(2) of the Code),

b. is permitted under the terms of the plan documents of the respective Component Plan, and

c. is made within thirty (30) days of the date the Participant experiences the Change in Status for which the Election Change is permitted.

2. Special Consistency Rules

a. Health Coverage. An Election Change to cancel or decrease the coverage of an individual who becomes eligible for coverage under another plan sponsored by the employer of a Participant's family member on account of a change in marital status or change in employment status will be deemed consistent with a Change in Status only if the individual actually enrolls for such coverage. An Election Change will not be deemed consistent with a Change in Status event that 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 if it cancels the coverage for any individual other than the affected spouse or dependent.

b. Life Insurance, AD&D and Disability Coverage. In the case of Life Insurance, AD&D and Long-term Disability Coverage, either an Election Change to increase coverage or an Election Change to decrease coverage in response to a Change in Status event will be deemed consistent with such Change in Status event.

3. A Participant who terminates employment during the Plan Year may, upon subsequent reemployment as an Eligible Employee during such Plan Year,

a. Reinstate the elections in effect as of the date employment terminated or,

b. Provided the prior termination of employment was not solely for the purpose of permitting the Participant to make an Election Change, make an Election Change for the remainder of the Plan Year.

An Eligible Employee who resumes employment within the same Plan Year as the date employment terminated without an intervening event that would otherwise permit an Election Change under this Section 3.07, shall only be permitted to reinstate the elections in effect as of the date employment terminated.

C. Changes in Cost

1. Automatic Changes. If the cost of a Benefit Option increases or decreases, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participant's Salary Reduction Contributions under the Plan.

2. Significant Cost Changes

   a. If the cost that a Participant is charged for a Benefit Option significantly increases, the Plan Administrator, in its sole discretion, may permit the Participant to:

      (1) Make a corresponding prospective increase in his or her Salary Reduction Contributions;

      (2) Revoke the election for that Benefit Option for the balance of the Plan Year and to elect Similar Coverage on a prospective basis; or

      (3) Drop coverage if Similar Coverage is not offered.

      To be effective, an Election Change must be made within the time specified by the Plan Administrator.

   b. If the cost charged for a Benefit Option significantly decreases, the Plan Administrator, in its sole discretion, may:

      (1) Permit a Participant who elected coverage under such Benefit Option for the Plan Year to make a corresponding prospective decrease in his or her Salary Reduction Contributions;

      (2) Permit all Participants, including those who did not elect coverage under such Benefit Option for the Plan Year, to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the Benefit Option with the decrease in cost on a prospective basis.

      (3) Permit Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the Benefit Option with the decrease in cost on a prospective basis.

      To be effective, an Election Change must be made within the time specified by the Plan Administrator.

c. In the case of a DCSA, an Election Change based on a change in the cost of care is permitted only if the cost change is imposed by a dependent care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related as described in Code Section 152(d)(2)(A)-(G), incorporating the rules of Code Section 152(f)(1). To be effective, an Election Change must be made within 31 days of the date of the cost change.

3. Notwithstanding the above, this subsection C. does not apply to an Election Change with respect to an HCSA or on account of a change in cost or coverage under an HCSA.

D. Coverage Changes

1. Addition or Significant Improvement in Benefit Option. If a new Benefit Option is added during the Plan Year or if coverage under a Benefit Option is significantly improved, the Plan Administrator, in its sole discretion, may:

a. Permit all Participants, including those who had not previously elected coverage under a Benefit Option providing Similar Coverage, to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the new or significantly improved Benefit Option on a prospective basis.

b. Permit Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and to elect to receive coverage under the new or significantly improved Benefit Option on a prospective basis.

To be effective, an Election Change must be made within the time specified by the Plan Administrator.

2. Significant Curtailment with Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that is a loss of coverage, the Plan Administrator, in its sole discretion, may permit the affected Participant to revoke his or her election of such Benefit Option and to elect Similar Coverage on a prospective basis or to drop coverage if no Benefit Option providing Similar Coverage is available. For this purpose, a loss of coverage means a complete loss of coverage under a Benefit Option, including the elimination of the Benefit Option, an HMO ceasing to be available in the area in which the individual resides or the individual losing all coverage under the Benefit Option by reason of a lifetime or

annual limitation. In addition, the Plan Administrator, in its sole discretion, may treat the following as a loss of coverage:

a. The withdrawal of a major hospital from a PPO network or a substantial decrease in the physicians participating in a PPO network or HMO;

b. The reduction in the benefits for which an employee or dependent is currently in a course of treatment.

c. Any other similar fundamental loss of coverage.

To be effective, an Election Change must be made within the time specified by the Plan Administrator.

3. Significant Curtailment without a Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that is not a loss of coverage as described in paragraph 2 above, the Plan Administrator, in its sole discretion, may permit the affected Participant to revoke his or her election of such Benefit Option and to elect Similar Coverage on a prospective basis. In no event will the Employee be permitted to drop coverage. For this purpose, coverage under a Benefit Option will be considered significantly curtailed only if there is an overall reduction in coverage provided under the plan generally, such as through a significant increase in the deductible, the copayment or the out-of-pocket cost sharing. To be effective, an Election Change must be made within the time specified by the Plan Administrator.

4. Changes in Coverage under a DCSA

a. A Participant may revoke his or her prior DCSA election and make a new election that reflects the change in dependent care provider. Such election shall be permitted regardless of whether the new provider is a household employee or family member of the Participant or is a dependent of the Participant. To be effective, an Election Change must be made within 31 days of the date that the new dependent care provider first provides dependent care services.

b. A Participant may revoke his or her prior DCSA election and make a new election that corresponds with a change in the number of hours of work performed by a dependent care provider. To be effective, the Election Change must be made within 31 days of the date the hours of work are first reduced.

5. Changes in Coverage under Another Employer's Plan. A Participant may make an Election Change that corresponds with a change made under another employer plan if:

   a. The change made under the other employer plan was on account of an event for which an Election Change is permitted under Code Section 125, or

   b. The period of coverage under the other employer plan is different than under this Plan.

   To be Effective, the Election Change must be made within 31 days of the date the coverage change is made under the other plan.

   Notwithstanding the above, an Election Change is permitted only if it is permitted under the terms of the relevant Component Plan. Any election change to drop coverage will be effective only with respect to those individuals who become covered under the other plan.

6. Loss of Other Group Health Coverage. An Eligible Employee may make a prospective Election Change to add coverage for the Employee, spouse or dependent, if coverage is lost under a group health coverage sponsored by a governmental or educational institution, including the following:

   a. A state's children's health insurance program under Title XXI of the Social Security Act;

   b. A medical care program of an Indian tribal government, the Indian Health Service or a tribal organization;

   c. A State health benefits risk pool; or

   d. A foreign government group health plan.

   To be effective, the Election Change must be made within 31 days of the date the other coverage is lost.

7. Notwithstanding the above, this subsection D. does not apply to an Election Change with respect to an HCSA or on account of a change in cost under an HCSA.

E. Other Permissible Changes

1. In the event a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including

a national medical support order) requires health coverage for an Eligible Employee's child, the Plan may:

a. Change the Employee's election to provide coverage for the child if the Order requires coverage under the plan maintained by the Employer, or

b. Permit the Employee to make an Election Change to cancel coverage for the child if the Order requires another individual to provide coverage and coverage is actually provided. To be effective, an Election Change must be made within 31 days of the date the Order is issued to the Employee.

2. Medicare and Medicaid

a. If an Eligible Employee or the Employee's Spouse or Dependent covered under a Health Benefit Plan Option enrolls for coverage under Medicare or Medicaid, the Employee may make an Election Change to cancel health coverage with respect to that individual.

b. If an Eligible Employee or the Employee's Spouse or Dependent enrolled in Medicare ceases to be eligible for such coverage, the Employee may make an Election Change to enroll the affected individual in a Health Plan Benefit Option as otherwise permitted under the terms of the Component Plan.

To be effective, an Election Change must be made within 31 days of the date the individual enrolls for Medicare or Medicaid as described above or loses eligibility for such coverage, as applicable.

F. Family and Medical Leave

1. Except as provided in paragraph 2. below, a Participant who goes on unpaid FMLA Leave may:

a. Revoke his or her election under a Health Plan Benefit Option at the onset of such leave or at any time during such leave; and

b. Revoke his or her election with respect to non-health benefits to the same extent as employees who are on unpaid leaves of absence other than FMLA Leave are permitted to revoke such elections.

Upon return from FMLA Leave, an Eligible Employee who has revoked an election may choose to reinstate such election, provided, however, that an Employer may require reinstatement of the election if employees who return

from a period of unpaid leave not covered by the FMLA are also required to resume participation under a Benefit Option upon return from leave.

2. A Participant shall not be permitted to revoke his or her election if the Employer continues the Participant's coverage while such Participant is on FMLA Leave but allows the Participant to discontinue his or her share of the contributions towards such coverage during the period of FMLA Leave. In such event, the Employer may recover the Participant's share of contributions when the Participant returns to work as provided in Section 3.05.

3. A Participant who is on FMLA Leave shall have the same right to make, revoke or change elections as described in Section 3.03 and subsections A., B., C., D., and E. of this Section 3.07 as other employees participating in the cafeteria plan who are working and are not on FMLA Leave.

G. Effective Date of Election Changes

An Election Change made pursuant to this Section 3.07 above shall be effective as of the date such change is effective under the respective Component Plan, except that in the case of an Election Change described in Section 3.07 A. above, other than Election Change involving the addition of a new dependent through birth, adoption or placement for adoption, such change shall be effective with the pay period which begins coincident with or immediately following the date the new election is accepted by the Plan Administrator, regardless of when coverage becomes effective under the Component Plan. With respect to the Benefit Options described in Articles V and VI, such changes shall be effective with the pay period which begins coincident with or immediately following the first day of the calendar month after the date the new Election Change is accepted by the Employer.

## ARTICLE IV

## Contributions

4.01 Salary Reduction Contributions

A Participant may elect to reduce his Compensation for a Plan Year and to use such amounts to purchase one or more benefits offered under one or more Component Plans and under Articles V and VI of this Plan. The monetary amount associated with this election constitutes Salary Reduction Contributions. Such Salary Reduction Contributions shall be authorized by the Participant on the Election Form or other form of enrollment authorized by the Employer. Salary Reduction Contributions are considered to be contributions made by the Employer on behalf of a Participant.

The amount of the reduction in the Participant's Compensation for the Plan Year for the coverage described in Articles V and VI of this Plan shall be the coverage amount elected for each benefit by the Participant, subject to the limitations contained in those respective Articles. The amount of the reduction in the Participant's Compensation for the Plan Year for coverage under any Component Plan shall equal the Participant's share of the cost of such coverage as determined by the Employer and specified for the Plan Year.

4.02 Non-elective Employer Contributions

An Employer may make Non-elective Employer Contributions with respect to a Participant for each Plan Year in such amounts as such Employer in its discretion may from time to time determine. Such amounts shall be allocated in equal amounts to each similarly-situated Participant.

A Participant may elect to waive coverage under the available Benefit Options as defined in the terms of the Component Plans. Non-elective Employer Contributions that are not allotted to Benefit Options shall be paid to the Employee in cash in accordance with Plan procedures.

4.03 Employee After-Tax Contributions

Under certain circumstances, a Participant may pay for coverage under certain Benefit Options from Compensation that has been subject to federal income taxes. The monetary amount associated with these payments constitutes Employee After-Tax Contributions. Employee After-Tax Contributions may be made for the following purposes:

A. To pay for coverage of a domestic partner or any other individual who may not be treated as a dependent of the Participant under any applicable section of the Code;

B. To pay for continuation of coverage during unpaid FMLA Leave as described in Section 4.05;

C. To pay for continuation of coverage under the HCSA as described in Section 5.10; or

D. For such other purposes as determined by the Plan Administrator on a nondiscriminatory basis for all similarly situated Participants.

4.04 Contributions by Participants on Approved Leaves of Absence other than Unpaid FMLA Leave

A Participant who is on an approved leave of absence other than unpaid FMLA Leave and who is otherwise eligible to continue to receive benefits under this Plan while on such leave shall make contributions required to purchase benefits under the Plan as provided below:

A. A Participant who is on a paid leave of absence shall have his Compensation reduced in the same manner and in the same amount as if he was not on such leave.

B. A Participant who is on unpaid leave of absence shall:

1. Make direct premium payments to the Plan each pay period. Such payments shall be in the amount determined in accordance with the Employer's leave of absence policy.

2. Make contributions to the Plan in such other manner as may be agreed to by the Plan Administrator and the Participant.

4.05 Contributions by Participants for Coverage Continued During Unpaid FMLA Leave

A. Except as provided below, a Participant who continues coverage while on unpaid FMLA Leave shall utilize the "pay-as-you-go" method to pay for such coverage. Under the "pay-as-you-go" method, the Participant shall pay his or her share of the cost of such coverage by making direct contributions to the Plan on the same schedule as contributions would be made if the Participant was not on leave or under any other payment schedule permitted under 29 CFR §825.210(c), under the Employer's existing rules for payment by employers on other types of unpaid leave, or under any other system voluntarily agreed to between the Participant and the Employer that is not inconsistent with 26 CFR §1.125-3 or 29 CFR §825.210(c).

B. The Plan Administrator, in its sole discretion, may also permit a Participant to pay for coverage continued during a period of FMLA Leave under either of the following methods of payment:

1. Pre-pay method. Under the "pre-pay" method, a Participant pre-pays the amounts due for coverage continued during the FMLA Leave period prior to the commencement of the FMLA Leave, or

2. Catch-up method. Under the "catch-up" method, the Participant pays for his or her share of the cost of coverage continued during FMLA Leave after returning from FMLA Leave. This method of payment may be utilized only if the Employer and the Participant agree in advance of the coverage period that:

   a. The Participant elects to continue health coverage while on unpaid FMLA Leave;

   b. The Employer assumes responsibility for advancing payment of the premiums on the Participant's behalf during the FMLA Leave; and

   c. These amounts are to be paid by the Participant when the Participant returns from FMLA Leave.

   Notwithstanding the above, the Employer may utilize the "catch-up" method to recoup the Participant's share of the cost of continued coverage without obtaining the prior agreement of the Participant under the following circumstances:

   a. The Employer chose to continue the Participant's coverage during FMLA Leave and allowed the Participant to discontinue payment of his or her share of the cost of coverage during the duration of such leave; or

   b. The Employer continued the coverage of a Participant who had previously elected to continue coverage during FMLA Leave after such Participant failed to make required payments.

C. Basis of Payment. Participant contributions under any method of payment may be made on an after-tax basis. In addition, the Employer may permit a Participant to make contributions on a salary reduction basis as follows:

1. Contributions may be made on a salary reduction basis under the "pay-as you go" method of payment to the extent that they are made from taxable compensation due the Participant during the FMLA Leave period.

2. Contributions under the "pre-pay" method of payment may be made on a salary reduction basis from any taxable compensation, provided that in the event the period of FMLA Leave spans two Plan Years, pre-payment on a salary reduction basis may not be made for the period of FMLA Leave that falls in the subsequent Plan Year.

3. Contributions under the "catch-up" method of payment may be made on a salary reduction basis from any available taxable compensation after the Participant returns from FMLA Leave, provided that the Participant has not made any other contributions towards such coverage on an after-tax basis.

At the Employer's discretion, taxable compensation may also include compensation attributable to unused sick days or unused vacation days.

D. Notwithstanding the above, in no event will the payment methods for Participants on FMLA Leave be offered on terms less favorable as those offered to Participants who are not on FMLA Leave.

4.06 Maximum Amount of Contributions

The maximum amount of Salary Reduction Contributions for each Plan Year is the sum of the cost of the most expensive of the Benefit Options and the maximum allowable contributions for the Health Care Spending Account and Dependent Care Spending Account, as set forth in Articles V and VI, reduced by the maximum amount of Non-elective Employer Contributions for such Plan Year.

The maximum amount of Non-elective Employer Contributions for any Plan Year is the maximum amount determined by the Employer and specified on the Election Form for each Plan Year, which is incorporated by reference herein.

If a new Employee becomes a Participant after a Plan Year has commenced, the maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions made available to such Participant for the balance of the Plan Year shall be prorated on the basis of the number of Contribution Pay Periods remaining in such Plan Year.

## ARTICLE V

## Health Care Spending Account Plan

5.01 Health Care Spending Account

The Benefit Option described in this Article is intended to qualify as a nontaxable employee benefit under Section 105 of the Code, providing health care benefits to Participants. The provisions of this Article are to be interpreted in a manner consistent with the requirements of Section 105 and Section 125 of the Code. All other provisions of this Plan shall be applied to, and will govern with respect to, this Health Care Spending Account Plan, unless expressly contradicted by a provision within this Article or by a provision of any applicable law or regulation.

5.02 Definitions

The following definitions shall apply for the purposes of this Article V:

A. "Authorized Representative" means an individual who has been designated in writing by claimant as authorized to file and pursue a claim or to file an appeal on a claimant's behalf. An assignment for purposes of payment to a health care provider does not constitute the appointment of an authorized representative under these claims procedures.

B. "Dependent" means an individual who is a dependent of the Participant as defined in Section 152 of the Internal Revenue Code, without regard to subsections (b)(1), (b)(2) and (d)(1)(B) , or a child of a Participant (as defined in Section 152(f)(1)) who as of the end of the applicable Plan Year has not attained age 27.

C. "Eligible Expense" means any expense that meets all of the following requirements:

1. It is an expense for medical care as defined in Section 213(d) of the Code, excluding premiums paid for other health insurance or plan coverage. However, an expense for medicines and drugs (other than insulin) shall qualify as an Eligible Expense only if such medicine or drug was prescribed for the Participant or a Dependent, regardless of whether such medicine or drug was available without a prescription. For this purpose, a prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense was incurred and that is issued by an individual who was legally authorized to issue a prescription in that state.

2. It is incurred by the Participant, the Participant's spouse or a Dependent.

3. It is neither covered, paid for, or reimbursed under an insurance policy or any health plan other than this Health Care Spending Account.

4. It is incurred with respect to a Plan Year while the individual is a Participant under this Benefit Option;

5. It is an expense for which adequate substantiation has been provided.

For purposes of subparagraph 4. above, an expense shall be deemed "incurred" as of the date the service is rendered or purchases are made from which the expense arises, regardless of when the Participant or his Dependent was actually billed or paid for the expense. In the case of supplies such as eyeglasses or prescription medications, such supplies are deemed to be incurred at the time they are ordered, not when paid for or received. Certain dental procedures such as crowns, bridges and root canal services are deemed incurred on the date initially started.

Orthodontic expenses shall be considered incurred in accordance with the following rules: Up to one-third of the total treatment expense shall be considered incurred on the date treatment begins. The remainder of the expenses shall be pro-rated over the course of the treatment, with each portion considered incurred as of the date of the provider's regular billing cycle. In the event that the employee pays the entire expense prior to the end of the course of treatment, expenses shall be considered incurred on an equal monthly basis.

An expense is "incurred with respect to a Plan Year" if it is incurred during such Plan Year.

5.03 Establishment of Health Care Spending Accounts

A Health Care Spending Account shall be established for each Plan Year with respect to each Participant who has elected to receive the Health Care Spending Account Benefit Option for the Plan Year. Subject to Section 5.04, a Participant's Health Care Spending Account shall be credited with the sum of the dollar amount that the Participant has elected to contribute to the HCSA for the Plan Year through Salary Reduction and the dollar amount of any Non-elective Employer Contributions allocated to a Participant's Health Care Spending Account. A Participant's Health Care Spending Account for each Plan Year shall be debited from time to time in the amount of any payment made pursuant to Section 5.07.

5.04 Limitations on Contributions

A. The maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions that a Participant may elect to allocate to this benefit is $5,000 for any Plan Year. The minimum amount that a Participant may elect to contribute with respect to any Plan Year is $26.

B. Except as provided by Section 4.05 and Section 5.05, the amount of Salary Reduction Contributions for the Plan Year shall be contributed in substantially

equal payments throughout the Plan Year. The number of payments shall equal the number of Contribution Pay Periods (as are expected to occur with respect to an individual Participant) in the Plan Year, or portion thereof, during which the Employee is a Participant in this Plan. The payments shall be made on each pay date during which the individual is a Participant.

C. Subject to the terms of Section 5.06, the maximum benefit payable by this Plan for reimbursement of a Participant's Eligible Expenses shall be equal to the Salary Reduction Contributions and Non-Elective Employer Contributions.

5.05 Limitation on Changes in Elections

A Participant may revoke his Health Care Spending Account election and make a new Health Care Spending Account election with respect to the remainder of the Plan Year in accordance with the terms of Section 3.07 of this Plan. In the event a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, shall be applicable only to Eligible Expenses incurred after the date the election is effective.

5.06 Limitations on Benefits

No reimbursement shall be made to a Participant with respect to any Plan Year from a Health Care Savings Account for any expense:

A. That was not an Eligible Expense;

B. That was not incurred during such Plan Year;

C. That was submitted after the earlier of thirty (30) days following the date of termination of employment or the last day of July of the following Plan Year, or

D. That, when taken together with prior reimbursements received by the Participant for that Plan Year, exceeds the amount of the Participant's Health Care Savings Account election for the Plan Year in effect on the date such expense was incurred.

5.07 Claims for Reimbursement

A. Except as provided in paragraph B. below, a Participant must request reimbursement of Eligible Expenses, as applicable, by completing the appropriate application form that includes:

1. A written statement or confirmation from an independent third party stating that the Eligible Expense has been incurred and the amount of such expense;

2. A written statement or confirmation from the Participant that the Eligible Expense has not been reimbursed or is not reimbursable under any other health plan coverage; and

3. Such other information as the Claim Administrator may from time to time require.

The request shall be accompanied by explanations of benefits, bills, invoices, receipts or other statements or certifications showing the amounts of such expenses, together with any additional documentation that the Claim Administrator may require. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

B. Notwithstanding the above, through contractual arrangement, certain Eligible Expenses incurred by individuals enrolled in a Health Plan Benefit Option may be automatically submitted to the Claim Administrator on behalf of the Participant without the need for the Participant to submit a claim for reimbursement or to provide additional substantiation.

C. Payment of claims shall be made directly to Participant seeking reimbursement, and shall not be made directly to the provider of any services giving rise to such claim. Except for expenses or automatically submitted as described in paragraph B. above, the Participant must submit the application for reimbursement of expenses for a Plan Year no later than the last day of July following the Plan Year with respect to which the Eligible Expense was incurred. Reimbursement will be made as soon as practical after complete documentation has been submitted by the Participant and approved by the Claim Administrator but in no event later than the time specified in Section 5.09. In the event of the Participant's death, the Participant's spouse (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article.

5.08 Determination of Claims

A. A claimant will receive written notification of any claim denial within 90 days after receipt of the claim or receipt of any information requested by the Claim Administrator as necessary to decide the claim. The period may be extended an additional 90 days if necessary due to matters beyond the control of the Plan, provided the Claim Administrator notifies the claimant of the circumstances that require the extension prior to the expiration of the initial 90-day period.

B. Notification of any claim denial shall be provided within the applicable time frame described in A. above.

5.09 Procedures for Appealing a Claim Denial

A A claimant shall have 60 days following receipt of a notification of a claim denial in which to appeal the determination to the Plan Administrator.

B. Notification of a claim denial on review shall be provided no later than 60 days after receipt of the claimant's request for review of the denial. This period may be extended an additional 60 days with advance notice from the Plan Administrator.

C. The decision of the Plan Administrator is final.

D. Authorized Representatives. A claimant's Authorized Representative may act on behalf of a claimant at any stage of these claims procedures. Once an Authorized Representative has been appointed, the Plan shall direct all information and notices to the Authorized Representative. The claimant shall be copied on all notifications regarding decisions unless the claim provides specific written direction otherwise. Any reference to a claimant in these claims procedures is intended to include the claimant's Authorized Representative.

5.10 Continuation of Coverage

A. FMLA Leave

1. A Participant who is on an unpaid FMLA Leave may choose to maintain his coverage under the Health Care Spending Account Benefit Option for the duration of his FMLA Leave at the level and under the conditions that such coverage would have been provided if he had continued in active employment. The Participant's right to maintain such coverage will terminate when:

(a) The Participant terminates employment by either notifying the Employer that he does not intend to return from FMLA Leave or by failing to return from FMLA Leave when such leave is exhausted,

(b) The Participant's employment would have terminated and coverage would have been lost if he had not taken FMLA Leave as the result of lay-off or the down-sizing of the Employer; or

(c) The Participant fails to make a required contribution for such coverage, if any, within the later of 30 days of the date due or 15 days after the Employer notifies the Employee that his coverage will end for failure to make required contributions. Coverage shall cease as of the last day of the period for which the last contribution was made.

Participant contributions for continuing coverage under the Health Care Spending Account shall be made in accordance with the terms and conditions of Section 4.06.

2. At the expiration of the FMLA Leave, a Participant whose coverage had ceased either because he had revoked his HCSA election pursuant to Section 3.07 or because he had failed to make required contributions may resume coverage by making contributions to his Health Care Spending Account. To the extent required by law, the Participant shall be given the choice between:

   (a) Resuming coverage at the level in effect immediately prior to his FMLA Leave and making up any contributions that were not made during the FMLA Leave, or

   (b) Resuming coverage at a level that is reduced on a pro rata basis for the period during the FMLA Leave for which no contributions were made with contributions due in the same monthly amount payable immediately prior to FMLA Leave.

   In both instances, the coverage level shall be reduced by prior reimbursements.

3. In no event shall a Participant receive reimbursement for Eligible Expenses incurred while coverage under the Health Care Spending Account was not in effect.

B. <u>COBRA and USERRA</u>

1. A former Participant or other qualified beneficiary, as defined in Section 2208 of the PHSA, who has a qualifying event, as defined in Section 2203 of the PHSA, may elect to continue his or her coverage under the Health Care Spending Account Benefit Option under COBRA. Coverage under an HCSA that qualifies as an "excepted benefit" under Treasury Regulation §54.9831-1(c)(3)(v) may be continued for the remainder of the Plan Year in which the qualifying event occurs. Coverage under an HCSA that does not qualify as an "excepted benefit" under Treasury Regulation §54.9831-1(c)(3)(v) may be continued as provided in Section 2202 of the PHSA.

   To continue coverage under COBRA, a Participant must make direct and timely contributions to the Employer. The amount of the contributions may be subject to a surcharge in the sole discretion of the Plan Sponsor, but shall not exceed the maximum permitted under applicable federal law. To the extent required by COBRA, a qualified beneficiary who has elected to exercise his continuation of coverage rights under COBRA shall be treated as a Participant under the Plan. If continuation coverage is elected,

coverage shall be maintained and Eligible Expenses shall be reimbursed as provided in this Article V.

2. A Participant who is on a Military Leave may elect to continue his or her coverage under the Health Care Spending Account Benefit Option beyond the date such coverage would otherwise terminate by making direct and timely contributions to the Employer for the period during which such coverage is required to be maintained under USERRA. Continuation of coverage under this paragraph 2. shall run concurrently with the continuation of coverage provided in paragraph 1. The amount of the contributions shall not exceed the maximum permitted under applicable federal law. To the extent required by USERRA, a qualified beneficiary who has elected to exercise his continuation of coverage rights under USERRA shall be treated as a Participant under the Plan. If continuation coverage is elected, coverage shall be maintained and Eligible Expenses shall be reimbursed as provided in this Article V.

3. If an election to continue coverage under this provision is not made, coverage under the Health Care Spending Account Benefit Option will terminate on the last day of the pay period for which a required contribution was made. Reimbursement shall be made only for Eligible Expenses incurred prior to the date coverage under the Health Care Spending Account terminated and only if a request for reimbursement is made as provided in Sections 5.07 and 5.08. No such reimbursement shall exceed the amount of the Participant's election for the Plan Year on the day the Eligible Expense was incurred less prior reimbursements for such Plan Year.

4. The right of a Participant or other qualified beneficiary to continuation coverage under COBRA shall terminate effective as of the last day of the Plan Year in which the qualifying event occurs, or, if earlier, on the date one of the events specified in Section 4980B(f)(2)(B)(ii) or (iii) of the Code occurs. The right of a Participant beneficiary to continuation coverage under USERRA shall terminate on the earlier of the date such coverage is terminated for failure to pay a required premium or such coverage is no longer required to be maintained under USERRA.

5.11 Forfeitures

A. Any balance remaining in a Participant's Health Care Spending Account for any given Plan Year on the last day of July immediately following the end of the Plan Year shall be forfeited as soon as practicable after the period of time necessary for the Administrator to give due consideration to all requests for reimbursement.

B. In the event that the total amounts credited to all Health Care Spending Accounts for a Plan Year exceed total reimbursements for such Plan Year, the excess amounts shall not be retained by the Employer, but shall be: (1) used to defray

reasonable administrative expenses; (2) applied to reduce employee contributions for the next Plan Year; and/or (3) returned to participants on a per capita basis; provided however, that in no event will contributions be returned or allocated to a Participant on the basis of the amounts that were forfeited by such Participant and provided, further, that such allocations shall be made in a nondiscriminatory manner.

C. In the event a Participant fails to present a reimbursement check for payment within 12 months of issuance, the benefits represented by such check shall be forfeited. Such forfeited amounts shall be applied toward the administrative expenses of the Plan or shall revert to the Employer.

5.12 Mandatory Reduction of Contributions

The Plan Administrator retains the right to reduce any Participant's allocation of Salary Reduction Contributions to this account if necessary to prevent this Plan from being considered discriminatory under Code Section 125 or Code Section 105(h). Any action taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

## ARTICLE VI

## Dependent Care Spending Account

6.01 Dependent Care Spending Account

The Benefit Option described in this Article is intended to qualify as a nontaxable Employee benefit under Section 129(a) of the Code, providing dependent care assistance benefits to Participants. The provisions of this Article are to be interpreted in a manner consistent with the requirements of Section 125 and Section 129 of the Code. All other provisions of this Plan shall be applied to, and will govern with respect to, this Dependent Care Spending Account Benefit Option, unless expressly contradicted by a provision within this Article or by a provision of any applicable law or regulation.

6.02 Definitions

The following definitions shall apply for the purposes of this Article VI:

A. "Applicable Statutory Limit" means the smallest of the following:

1. The amount specified in Section 6.04 as determined by the Participant's marital and filing status;

2. The Participant's earned income for the calendar year; or

3. If the Participant is married at the end of the calendar year, the spouse's earned income for such calendar year, provided, however, that the earned income of a spouse who is a student or incapable of self-care shall be determined as provided in Section 21(d)(2) of the Code.

For purposes of this definition, "earned income" shall have the meaning set out in Section 129(e)(2) of the Code.

B. "Dependent" means a "qualifying individual" as defined in Section 21(b)(1) of the Code.

C. "Dependent Care Spending Account Balance" means the amount of contributions allocated to the Participant's Dependent Care Spending Account as of the last day of the pay period ending immediately before the date the expense is submitted.

D. "Eligible Expenses" means expenses that meet each of the following requirements:

1. They are considered employment-related expenses as defined in Section 21(b)(2) of the Code and the regulations thereunder.

2. They are for services which are provided during a period of time during which the Employee was a Participant under this Plan and had elected to participate in this Dependent Care Spending Account Benefit Option (regardless of when the Participant was actually billed or paid for those services), and which are provided while such election was in effect.

3. They are expenses for which the Participant has provided adequate substantiation.

6.03 Establishment of Dependent Care Spending Account

A Dependent Care Spending Account shall be established for each Plan Year with respect to each Participant who has elected to receive the Dependent Care Spending Account Benefit Option for the Plan Year. As of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's election shall be credited to a Participant's Dependent Care Spending Account for each Plan Year as Elective Employer Contributions. A Participant's Dependent Care Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Section 6.08.

6.04 Limitations on Contributions.

The maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions that a Participant may elect to allocate to this benefit is $5,000 for any Plan Year (or $2,500 in the case of a married Participant who is filing "separately" with regard to the Internal Revenue Service Form 1040). The minimum amount that a Participant may elect to contribute with respect to any Plan Year is $26.

6.05 Timing of Contributions

Except as may be permitted under Section 3.07, the amount of Salary Reduction Contributions for the Plan Year shall be contributed in substantially equal installments during the Plan Year. The number of installments shall equal the number of Contribution Pay Periods in the Plan Year, or portion thereof, during which the Employee is a Participant in this Plan. The installments shall be made on each Contribution Pay Period during which the individual is a Participant.

6.06 Limitation on Election Changes

A. A Participant may revoke his Dependent Care Spending Account election and make a new Dependent Care Spending Account election with respect to the remainder of the Plan Year in accordance with the terms of Section 3.07 of this Plan. In the event a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, shall

be applicable only to Eligible Expenses incurred after the date the election is effective.

B. A Participant may revoke his Dependent Care Spending Account election on a retroactive basis during the Plan Year if at the time of the election and at all times thereafter, the Participant did not have a Dependent, as defined in Section 6.02 A. above and the election clearly was based on a mistake of fact, as determined by the Plan Administrator.

6.07 Limitations on Reimbursements

No reimbursement shall be made to a Participant with respect to any Plan Year for any expense:

A. That was not an Eligible Expense;

B. That was not incurred during such Plan Year;

C. That was submitted after the earlier of thirty (30) days following the date of termination of employment or the last day of July of the following Plan Year; or

D. That exceeds the lesser of the following:

1. The amount of the Participant's election for the Plan Year in effect on the date such expense was incurred reduced by the amount of prior reimbursements made for that Plan Year.

2. The Participant's current Dependent Care Spending Account Balance.

In the event the expense for which reimbursement is sought exceeds subparagraph 2. but not subparagraph 1., the amount of the expense in excess of subparagraph 2. will be held for future reimbursement consideration within that current Plan Year.

In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the amount of prior reimbursements made for that Plan Year, would exceed the Participant's Applicable Statutory Limit.

6.08 Claims for Reimbursement

A. A Participant must request reimbursement of Eligible Expenses by completing the appropriate application form that includes:

1. A written statement from an independent third party stating that the Eligible Expense has been incurred and the amount of such expense;

2. The name and address social security number or tax identification number of the person, organization or entity to whom the Eligible Expense was or will be paid, or in the case of an organization exempt from tax under Section 501(c)(3) of the Code, the name and address of such organization; and

3. Such other information as the Claim Administrator may from time to time require.

The request shall be accompanied by bills, invoices, receipts or other statements or certifications showing the amounts of such expenses, together with any additional documentation that the Claim Administrator may require. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

B. A Participant may submit proof of payment for reimbursement consideration at any time on or before the last day of July following the close of the Plan Year in which the Eligible Expenses were incurred. Reimbursement will be made for Eligible Expenses as soon as practical after complete documentation has been submitted by the Participant and approved by the Claim Administrator. In the event of the Participant's death, the Participant's spouse (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article.

6.09 Determination of Claims

A. A claimant will receive written notification of any claim denial within 90 days after receipt of the claim or receipt of any information requested by the Claim Administrator as necessary to decide the claim. The period may be extended an additional 90 days if necessary due to matters beyond the control of the Plan, provided the Claim Administrator notifies the claimant of the circumstances that require the extension prior to the expiration of the initial 90-day period.

B. Notification of any claim denial shall be provided within the applicable time frame described in A. above.

6.10 Procedures for Appealing a Claim Denial

A A claimant shall have 60 days following receipt of a notification of a claim denial in which to appeal the determination to the Plan Administrator.

B. Notification of a claim denial on review shall be provided no later than 60 days after receipt of the claimant's request for review of the denial. This period may be extended an additional 60 days with advance notice from the Plan Administrator.

C. The decision of the Plan Administrator is final.

6.11 Forfeitures

Any balance attributable to Salary Reduction Contributions and Non-elective Employer Contributions, if applicable, for any given Plan Year remaining in a Participant's account on the last day of July immediately following the end of the Plan Year in which such contributions were made will be forfeited as soon as practicable after the period of time necessary for the Administrator to give due consideration to all requests for reimbursement.

In the event that the total amounts credited to all Dependent Care Spending Accounts for a Plan Year exceed total reimbursements for such Plan Year, the excess amounts may be retained by the Employer or, may be: (1) used to defray reasonable administrative expenses; (2) applied to reduce employee contributions for the next Plan Year; and/or (3) returned to participants on a per capita basis; provided however, that in no event will contributions be returned or allocated to a Participant on the basis of the amounts that were forfeited by such Participant and provided, further, that such allocations shall be made in a nondiscriminatory manner.

In the event a Participant fails to present a reimbursement check for payment within 12 months of issuance, the benefits represented by such check shall be forfeited. Such forfeited amounts shall be applied toward the administrative expenses of the Plan or shall revert to the Employer.

6.12 Mandatory Reduction of Contributions

The Plan Administrator retains the right to reduce any Participant's allocation of Salary Reduction Contributions to this account in accordance with the terms of Section 3.06 of this Plan.

6.13 Statements

Each Participant who has had contributions made to a Dependent Care Spending Account during the Plan Year shall be furnished with a written statement showing a reasonable estimate of the amount of Eligible Expenses reimbursed from the account in accordance with applicable provisions of this Plan with respect to such Plan Year.

## ARTICLE VII

## Amendment or Termination

7.01 Right to Amend

The City Council through a formal resolution (or any person, entity, committee or group duly authorized by such City Council), shall have the right to make at any time any modification, amendment or amendments to this Plan; however, no amendment shall have any retroactive adverse effect on a Participant, unless the City Council determines such amendment is necessary or desirable to comply with applicable law.

7.02 Right to Terminate

The City Council, through a formal resolution (or any person, entity, committee or group duly authorized by the City Council), shall have the authority to terminate the Plan at any time in whole or in part; but in no event shall such termination prejudice any claim or benefit under the Plan that was incurred but not paid prior to the termination date.

## ARTICLE VIII

## Administration

8.01 Plan Administrator

The Plan Sponsor shall be the Plan Administrator. The Plan Administrator's principal duty shall be to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

8.02 Powers and Duties

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 will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

A. To establish a funding policy and method consistent with the objectives of the Plan and as required by law.

B. To determine and set the cost associated with each Benefit Option offered under this Plan. Such cost can be changed at any time prior to or during a Plan Year without prior notification to Participants or to the Employer.

C. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law.

D. To interpret the Plan, its interpretation in good faith to be final and conclusive on all persons claiming benefits under the Plan.

E. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan.

F. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan.

G. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, including, but not limited to, delegating certain claims administration duties to a claims administrator, provided that any such allocation, delegation or designation shall be set out in a written instrument executed by the Plan Administrator and the designated party.

H. To communicate to any insurer or other supplier or administrator of benefits under this Plan in writing all information required to carry out the provisions of the Plan.

I. To notify the Participants in writing of any substantive amendment or termination of the Plan or of a change in benefits available under the Plan.

J. To terminate any Affiliate's adoption of the Plan at any time.

Notwithstanding the provisions of this section, the powers and duties allocated to the Plan Administrator and described in this section shall only be applicable with respect to a claim arising under the Benefit Options or to the administration of the Benefit Options to the extent that such power or duty is not allocated (either expressly or by implication) to the individual(s) or entity appointed to serve as administrator of any of the Benefit Options.

8.03 Examination of Records

The Plan Administrator will make available to each Participant such records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

8.04 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions of, the administrators of any of the plans offered within the Plan, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

8.05 Nondiscriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.06 Standard of Review

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant is entitled to receive any benefit under the terms of this Plan, which interpretation shall be made by the Administrator in its sole discretion. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Administrator at the time it made the decision that is the subject of review.

## ARTICLE IX

## Miscellaneous Provisions

9.01 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.

9.02 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 Plan Sponsor, except as provided herein.

9.03 Governing Law

This Plan shall be construed, administered and enforced according to the laws of California except as may be preempted by federal law.

9.04 Facility of Payment

If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, death, illness or infirmity, mental incompetence or incapacity of any kind, the Plan Administrator may, in its discretion, take any one or more of the following actions:

A. Apply such amount directly for the comfort, support and maintenance of such person.

B. Reimburse any person for any such support previously supplied to the person entitled to receive any such payment.

C. Pay such amount to a legal representative or guardian or any other person selected by the Plan Administrator for the comfort, support and maintenance of the person entitled to receive such amount, including without limitation, any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution caring for such person. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any savings or commercial bank of the Plan Administrator's choice.

9.05 Lost Payee

Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward the administrative expenses of the Plan, or shall revert to the applicable Employer. However, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable if a claim is made by the Participant or beneficiary. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

9.06 No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the Employer neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to Article III will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to notify the Employer if the Participant has reason to believe that any payment made or to be made to the Participant pursuant to the Plan is not excludable from the Participant's gross income for federal, state or local income tax purposes.

9.07 Funding

Payments due under the Plan will be made from the general assets of the Employer or otherwise provided by a third party insurance company with whom the Plan Administrator has contracted to provide certain benefits, and no funds will be placed in escrow or earmarked to pay benefits.

9.08 Indemnification of Employer by Participant

If a Participant receives one or more payments in accordance with applicable Plan provisions that are not for eligible dependent care expenses or eligible medical expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from such payments. Such indemnification and reimbursement shall not exceed the sum of the amount of additional federal and state income tax that the Participant would have owed if the payments 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.

## ARTICLE X

### Provision of Protected Health Information To Employer

10.01 Permitted Disclosures of Protected Health Information

Unless otherwise permitted or required by law, and subject to obtaining written certification pursuant to Section 13.04, the Component Plan that is a Health Plan as defined in 45 CFR §160.103 may disclose Protected Heath Information (as defined in 45 CFR §160.103) to an Employer only for the purpose of enabling an Employer to perform administrative functions related to the treatment, payment and health care operations of such Health Plan as defined in 45 CFR §164.501.

In no event shall an Employer be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

10.02 Conditions of Disclosure

The Employer agrees that with respect to any Protected Health Information disclosed to it by the Health Plan that it shall:

A. Not use or further disclose the Protected Health Information other than as permitted or required by the Health Plan or as required by law.

B. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to Protected Health Information.

C. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

D. Report to the Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

E. Make available Protected Health Information in accordance with 45 CFR §164.524.

F. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.

G. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

H. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with subpart E of 45 CFR §164.

I. If feasible, return or destroy all Protected Health Information received from the Health 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.

J. Ensure that the adequate separation between the Health Plan and Employer, required in 45 CFR §504(f)(2)(iii), is satisfied.

K. If the Employer receives electronic protected health information, as defined in 45 CFR §160.103, it shall:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

2. Ensure that the adequate separation between the Plan and the Employer with respect to electronic protected health information is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information to implement reasonable and appropriate security measure to protect the electronic protected health information; and

4. Report to the Plan any security incidents of which it becomes aware concerning electronic protected health information.

10.03 Separation Between Health Plan and Employers

To satisfy the requirements of Section 10.02 J. above, the following conditions shall apply:

A. Protected Health Information may only be used and/or disclosed by the Plan to employees employed in the human resources department of an Employer who are engaged in activities related to plan administration functions, or in other departments that have oversight responsibility for the plan, including employees

with oversight responsibility for claims payment and third party claims administration

B. The access to and use of Protected Health Information by the individuals described in Section 13.03 A. above shall be restricted to the plan administration functions that the Employer performs for the Health Plan.

C. An individual described in Section 10.03 A. above who fails to comply with the provisions of the plan document relating to the use and disclosure of Protected Health Information shall be subject to disciplinary action under the Employer's established policies and procedures.

10.04 Certification

The Health Plan shall disclose Protected Health Information to an Employer only upon the receipt of a certification that the plan document has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.02. The Health Plan shall not disclose Protected Health Information to the Employer as otherwise permitted herein unless the statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and behalf effective the 1st day of July, 2012, by its designee thereunto duly authorized.

**THE CITY OF SAN DIEGO**

_____
Signature

_____
Printed Name

_____
Title

**CITY OF SAN DIEGO**
**SECTION 125 PLAN**

## APPENDIX A

A Participant in this Plan may elect coverage under the following Component Plans:

1. HealthNet HMO Medical
2. HealthNet PPO Medical
3. Kaiser Medical
4. Sharp HMO Medical
5. MEA Medical
6. POA Medical
7. Local 145 Medical
8. Concordia Plus DHMO Dental
9. Concordia Preferred DPO Dental
10. MEA Dental
11. Local 127 Dental
12. Blue Shield of CA / MESVision
13. MEA Vision
14. Health Care Spending Account
15. Dependent Care Spending Account
16. Basic Term Life Insurance with AD&D

FY 13 ANNUAL FLEXIBLE BENEFITS ALLOTMENT

MEA represented employees $ 6,075

Local 127 represented employees with Medical coverage $ 5,575
Local 127 represented employees Waiving Medical coverage $ 4,575

POA represented employees
No Medical coverage $ 1,500
Employee only $ 3,837
Employee & Children $ 5,814
Employee & Spouse/Domestic Partner $ 6,280
Employee & Spouse/Domestic Partner & Children $ 7,588

Local 145 represented employees
No Medical coverage $ 1,750
Employee only $ 4,750
Employee & Children $ 7,225
Employee & Spouse/Domestic Partner $ 7,800
Employee & Spouse/Domestic Partner & Children $ 9,400

DCAA represented employees
No Medical coverage $ 3,220
Employee only $ 6,921
Employee & Children $ 9,346
Employee & Spouse/Domestic Partner $ 10,432
Employee & Spouse/Domestic Partner & Children $ 10,799

Unrepresented and Unclassified employees
No Medical coverage $ 4,500
Employee only $ 7,701
Employee & Children $ 10,126
Employee & Spouse/Domestic Partner $ 10,699
Employee & Spouse/Domestic Partner & Children $ 12,294