RESOLUTION NUMBER R- 309630

DATE OF FINAL PASSAGE MAY 05 2015

A RESOLUTION OF THE COUNCIL OF THE CITY OF SAN DIEGO, PURSUANT TO SECTION 14 OF THE FISCAL YEAR 2016 SALARY ORDINANCE, ESTABLISHING AND ADOPTING A CAFETERIA BENEFITS PLAN FOR DESIGNATED ELIGIBLE EMPLOYEES FOR FISCAL YEAR 2016.

WHEREAS, the Salary Ordinance for Fiscal Year 2016 (Salary Ordinance) was introduced to the Council of the City of San Diego (City Council) on April 6, 2015; and

WHEREAS, the Salary Ordinance will be docketed for adoption in accordance with San Diego Charter section 290(a); and

WHEREAS, section 14 of the Salary Ordinance provides that the Council may establish additional benefit programs, upon the Mayor's recommendation; and

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

WHEREAS, the Flexible Benefits Plan is intended to provide eligible employees a choice between certain taxable and nontaxable benefits offered under the Flex Plan; and

WHEREAS, the Flexible Benefits Plan is a cafeteria plan under section 125 of the Internal Revenue Code, and must be interpreted consistently with that section and related guidance issued by the Internal Revenue Service; and

952466

WHEREAS, the City Council desires to adopt the Flexible Benefits Plan for Fiscal Year 2016, effective as of July 1, 2016; NOW THEREFORE,

BE IT RESOLVED that, pursuant to section 14 of the Fiscal Year 2016 Salary Ordinance, the City Council adopts the Flexible Benefits Plan, which is Attachment A to this Resolution, for all designated eligible employees for Fiscal Year 2016.

BE IT FURTHER RESOLVED that the credits for flexible benefits for eligible employees under the Flexible Benefits Plan for Fiscal Year 2016 are adopted as set forth in Attachment B to this Resolution, and the amounts in Attachment B are the total amount of flexible benefits allotted 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 Flexible Benefits Plan.

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

APPROVED: JAN I. GOLDSMITH, City Attorney

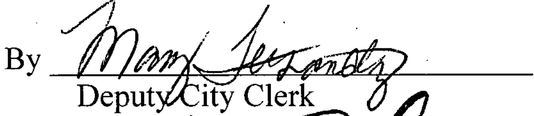
By

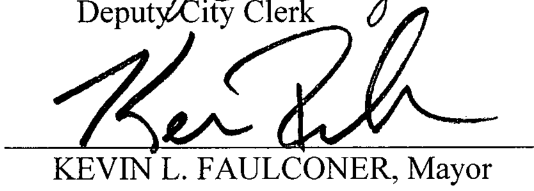
Roxanne Story Parks
Deputy City Attorney

RSP:ccm
April 6, 2015
Or.Dept: Personnel
Doc. No.: 952466

I certify that this Resolution was passed by the Council of the City of San Diego, at this meeting of APR 21 2015.

ELIZABETH S. MALAND
City Clerk

By 
Deputy City Clerk



Approved: 4/29/15
(date)

KEVIN L. FAULCONER, Mayor

Vetoed: ____________
(date)

KEVIN L. FAULCONER, Mayor

CITY OF SAN DIEGO

FLEXIBLE BENEFITS PLAN

**Amended and Restated as of
July 1, 2015**

Item 332 - Attachment A

City of San Diego Flexible Benefits Plan

Table of Contents

Introduction		1
Article I	Definitions	2
Article II	Participation	6
Article III	Election of Benefits	7
Article IV	Contributions	17
Article V	Health Care Spending Account	21
Article VI	Dependent Care Spending Account	28
Article VII	Amendment or Termination	33
Article VIII	Administration	34
Article IX	Miscellaneous Provisions	36
Article X	Provision of Protected Health Information to Employer	38
Appendix A		

INTRODUCTION

The City of San Diego (the Plan Sponsor) previously established the City of San Diego Flexible Benefits Plan (the 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 July 1, 2015.

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. The following words and phrases have the following meanings unless a different meaning is plainly required by the context.

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 an Eligible Employee, or the spouse or dependent of an Eligible Employee:

(i) 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

(ii) any other change in employment status that affects the individual's eligibility for benefits under a plan;

(d) An event that causes an Eligible Employee's dependent to satisfy or cease to satisfy the definition of Eligible Dependent under the relevant Component Plan; or

(e) A change in the place of residence or work of an Eligible Employee or the Eligible Employee's spouse or dependent.

1.03 "City" means the City of San Diego.

1.04 "City Council" means the elected legislative body of the City of San Diego.

1.05 "Claims Administrator" means the Plan Administrator, or a third party designated by the Plan Administrator to determine claims for benefits under the Plan.

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

1.07 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

1.08 "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 the Employer during a Plan Year, before any reductions under a Salary Reduction Agreement or other Employer-sponsored plan under this Plan.

1.09 "Component Plan" means the plans maintained by the Employer that are listed in Appendix A, including but not limited to:

(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 described in Article VI.

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 under the terms of a Component Plan, including a Participant's domestic partner who has satisfied all conditions for eligibility and who qualifies as the Participant's tax dependent as defined in section 152 of the Code, without regard to subsections (b)(1), (b)(2) and (d)(1)(B), or a Participant's child (as defined in section 152(f)(1)) who has not reached age 27 by the end of the applicable Plan Year. "Dependent" also means an individual whose expenses are eligible for reimbursement under a Participant's Health Care Spending Account or Dependent Care Spending Account.

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 remainder 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 elects his or her benefits under the Plan, and by which the Eligible Employee agrees to make Salary Reduction Contributions 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 or her Election Form.

1.15 "Eligibility Date" means the date the Employee becomes eligible for benefits, which 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 becomes an Eligible Employee.

1.16 "Eligible Employee" means an Employee who is regularly scheduled to work at least 40 hours per payroll period and who is otherwise eligible to participate in one or more of the Component Plans. "Eligible Employee" does not include an hourly (no standard hours) Employee.

1.17 "Employee" means any person currently employed by and receiving compensation from the Employer. "Employee" does 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 the person is a common law employee of the Employer.

1.18 "Employee After-Tax Contributions" means after-tax contributions made by a Participant to purchase coverage offered under one or more Component Plans, as described in section 4.03.

1.19 "Employer" means the Plan Sponsor, the City.

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 a Component Plan that is a health plan providing medical, dental or vision care, including any plan offering benefits through a health maintenance organization.

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 USERRA.

1.25 "Non-elective Employer Contributions" means the contributions 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 VIII.

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

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

1.31 "PHSA" means the Public Health Service Act as amended from time to time.

1.32 "Salary Reduction Contributions" means the contributions 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 becomes a Participant on his Eligibility Date.

2.02 Termination of Participation

A Participant ceases to be a Participant upon the earliest of the following events:

(a) the date this Plan terminates;

(b) the date the Participant 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

(a) A Participant's coverage under any Benefit Option elected under this Plan terminates on the earlier of:

(i) the date specified in the plan document of the Component Plan or in Article V, VI, or VIII of this Plan; or

(ii) the end of each Plan Year.

(b) A Participant may obtain coverage for subsequent Plan Years only in accordance with the election procedures in section 3.03.

(c) Notwithstanding anything to the contrary in this section 2.03, 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 that is a Health Plan beyond the date that coverage would otherwise terminate. The terms and conditions of that continued coverage are set out in the Component Plan's plan document. The Contributions to maintain continuation of coverage must be made directly to the Plan Administrator or insurance carrier as applicable and may not be made under this Plan, except as otherwise provided under section 3.07(e)(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 listed in Appendix A. Enrollment in any of the Component Plans is governed by the terms and conditions of that Component Plan's plan document.

No benefits under the Plan may be provided in the form of deferred compensation, except that, in accordance with Code section 125 and the regulations under that section, a Participant may elect to defer cash Compensation available under this Plan into an Employer-sponsored retirement plan that is qualified under Code section 401(a) and contains a cash or deferred arrangement under Code section 401(k) (i.e., a 401(k) plan), but only to the extent permitted under the terms of that retirement plan. The actual terms and conditions of any such 401(k) plan will be contained in a separate, written document.

3.02 Election Procedures Upon Initial Eligibility

When an individual becomes an Eligible Employee, the Plan Administrator will provide the Employee an Election Form or other enrollment method, on which the Eligible Employee will: (a) elect his or her Benefit Options for the Plan Year, and (b) agree to make Salary Reduction Contributions as provided in Article IV. If the Eligible Employee enrolls within the 31 days after his or her Eligibility Date (or within 60 days as specified in section 3.07(a)), the Employee's coverage under his or her selected Benefit Options will begin on his or her Eligibility Date.

Notwithstanding the preceding paragraph, if a Component Plan provides for mandatory participation or for automatic enrollment in a Benefit Option absent an election by the Eligible Employee, the Eligible Employee will be deemed to have elected coverage under that Benefit Option and to have consented to any required Salary Reduction Contributions.

3.03 Annual Enrollment Procedures

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

Notwithstanding the preceding paragraph, if a Component Plan provides for mandatory participation or automatic enrollment in a Benefit Option absent an election by the Eligible Employee, the Eligible Employee will be deemed to have elected coverage under that Benefit Option and to have consented to any required Salary Reduction Contributions.

3.04 Failure to Complete Election Process

(a) Unless 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 will deemed to have elected to receive his or her 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 will be deemed to have: (1) elected to continue the Benefit Options he or she elected most recently on file with the Plan Administrator; and (2) agreed to have his or her Compensation reduced by whatever amount is then necessary to purchase those Benefit Options.

(c) If a Benefit Option in which a Participant was enrolled is eliminated for the subsequent Plan Year, the Plan Administration may enroll the Participant in a Benefit Option providing Similar Coverage, if available, as determined by the Plan Administrator. All similarly-situated Participants will be enrolled in the same Benefit Option.

3.05 Duration of Elections

A Participant's election is irrevocable and remains in effect through the last day of the Plan Year except as provided in section 3.07or in the applicable 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 before or during a Plan Year, to the extent necessary to prevent this Plan from being considered discriminatory under section 79, 125(b), 105(h)(2), or 129(d)(2) of the Code.

(a) If a reduction under this section affects health benefits, the Plan Administrator may reduce the elections of only those Participants who are highly compensated, as defined in either section 105(h) or section 125(e) of the Code.

(b) If a reduction under this section affects other qualified benefits, the Plan Administrator may reduce the elections of only those Participants who are highly compensated, as defined in section 125(e) of the Code, or who are otherwise key employees as defined in section 125(b) of the Code.

(c) If a reduction under this section affects dependent care assistance benefits under section 129 of the Code, the Plan Administrator may reduce the elections of only those Participants who are officers, owners or highly compensated individuals as defined in section 129(d) of the Code or their dependents.

3.07 Changes in Employee Elections

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

An Eligible Employee who has special enrollment rights under a group health plan under section 2704(f)(3) of the PHSA may make an Election Change with respect to that group health plan, if the Eligible Employee enrolls himself or herself 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 the date on which: (1) 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 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

(i) A Participant may make an Election Change with respect to the various Benefit Options offered under this Plan if the Election Change:

(A) is on account of and consistent with a Change in Status that affects eligibility for coverage either under one of the Employer's plans or under a particular benefit package option under one of the an Employer's plans; (B) is permitted under the terms of the relevant Component Plan; and

(C) is made within 30 days of the Participant's Change in Status for which the Election Change is permitted.

(ii) For the purpose of section 3.07(b)(i)(A), a Change in Status that changes the number of a Participant's family members who may benefit from coverage under the Employer's plan or option is deemed to affect eligibility for coverage. A Participant may make an Election Change with

respect to the DCSA Benefit Option only if the Election Change is on account of and 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).

(iii) Special Consistency Rules

(A) Health Coverage. A Participant may make 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, because of a change in marital or employment status, if the individual actually enrolls for that newly available coverage. A Participant will not be allowed to make an Election Change because of the Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to be eligible for coverage, if that event cancels the coverage for any individual other than the affected spouse or dependent.

(B) Life Insurance, AD&D and Disability Coverage. When a Participant makes an Election Change to either increase or decrease coverage under a Life Insurance, AD&D, or Long-term Disability policy in response to a Change in Status event, the Election Change will be deemed consistent with the Change in Status event.

(C) If an Eligible Employee terminates and resumes City employment within the same Plan Year, without an intervening event that would otherwise permit an Election Change under this section, the Eligible Employee will be permitted only to reinstate the elections in effect when he or she terminated.

(c) Changes in Cost

(i) Automatic Changes. If a Benefit Option's cost changes, the Plan Administrator may, on a reasonable and consistent basis, automatically change the affected Participant's Salary Reduction Contributions .

(ii) Significant Cost Changes

(A) If the cost to a Participant for a Benefit Option increases significantly, the Plan Administrator, in its sole discretion, may allow 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 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 Participant's cost for a Benefit Option decreases significantly, the Plan Administrator may, in its sole discretion:

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

(2) allow all Participants, including those who did not elect coverage under the Benefit Option, to revoke their elections for the balance of the Plan Year and elect to receive coverage under the Benefit Option that decreased in cost for the balance of the Plan Year; and

(3) allow Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and elect to receive coverage under the Benefit Option that decreased in cost for the balance of the Plan Year.

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 the cost changed.

(iii) Notwithstanding anything to the contrary, subsection (c) of section 3.07 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

(i) 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 may, in its sole discretion:

(A) allow 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 elect coverage under the new or significantly improved Benefit Option on a prospective basis; or

(B) allow only those Participants who elected coverage under a Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and elect 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.

(ii) Significant Curtailment with Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that constitutes a loss of coverage, the Plan Administrator may, in its sole discretion, allow the affected Participant to: (1) revoke his or her Benefit Option election and elect Similar Coverage on a prospective basis, or (2) 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 or

(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.

(iii) Significant Curtailment without a Loss of Coverage. If a Participant has a significant curtailment under a Benefit Option that does not constitute a loss of coverage under paragraph (ii) above, the Plan Administrator may, in its sole discretion, allow the affected Participant to revoke his or her election of that Benefit Option and elect Similar Coverage on a prospective basis, but may not allow the Employee 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, including 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.

(iv) 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, even if the new provider is the Participant's household employee, family member, or Dependent . 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 provider's hours of work are first reduced.

(v) 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 of the coverage change under the other plan.

An Election Change is permitted only if it is permitted under the relevant Component Plan. Any Election Change to drop coverage will be effective only as to those individuals who become covered under the other plan.

(vi) Loss of Other Group Health Coverage. An Eligible Employee may make a prospective Election Change to add coverage for the Employee, or the Employee's Spouse or Dependent, if coverage is lost under a group health plan 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's 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.

(vii) 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

(i) If 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) allow 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.

(ii) Medicare and Medicaid

(A) If an Eligible Employee, or the Employee's Spouse or Dependent, who is 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 for that individual.

(B) If an Eligible Employee, or the Employee's Spouse or Dependent, who is enrolled in Medicare ceases to be eligible for that 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 that coverage, as applicable.

(f) Family and Medical Leave

(i) Except as provided in paragraph (iii) 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 that leave, or at any time during that 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 their elections.

(ii) Upon return from an FMLA Leave, an Eligible Employee who revoked an election may choose to reinstate that election, provided, however, that the Employer may require reinstatement of the election if the Employer also requires employees who return from unpaid leave not covered by the FMLA to resume participation under a Benefit Option upon return from leave.

(iii) The Plan will not allow a Participant to revoke his or her election if the Employer continues and pays the full cost of the Participant's coverage while the Participant is on FMLA Leave. The Employer may recover the Participant's share of contributions towards coverage when the Participant returns to work from his or her FMLA Leave.

(iv) A Participant who is on FMLA Leave has 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 under this section 3.07 that involves the addition of a new dependent through birth, adoption, or placement for adoption, is effective on the date the change is effective under the relevant Component Plan. An Election Change under this section that does not involve the addition of a new dependent through birth, adoption, or placement for adoption is effective with the pay period

that 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. Election Changes related to the Benefit Options described in Articles V and VI are effective with the pay period that begins coincident with or immediately following the first day of the calendar month after the date the Employer accepts the new Election Change.

ARTICLE IV

Contributions

4.01 Salary Reduction Contributions

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

As to the benefits described in Articles V and VI, the amount of a Participant's Salary Reduction Contributions for the Plan Year is the total coverage amount selected by the Participant for these benefits, subject to the limitations contained in those Articles. The amount of the reduction in the Participant's Compensation for the Plan Year for coverage under one or more of the Component Plans listed in Appendix A equals the Participant's share of the cost of that coverage for the Plan Year, as determined by the Employer.

4.02 Non-elective Employer Contributions

The Employer may make Non-elective Employer Contributions on a Participant's behalf for each Plan Year in the amounts determined by the Employer in its discretion. These amounts will be allocated in equal amounts to similarly-situated Participants.

A Participant may elect to waive coverage under the available Benefit Options as defined in the terms of the Component Plans and in Articles V and VI. The Employer will pay Non-elective Employer Contributions that the Participant does not allot to Benefit Options in cash in accordance with Plan procedures and the governing Memoranda of Understanding between the City and its recognized employee organizations.

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 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 the Participant's dependent under the Code;

(b) to pay for continuation of coverage during an 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 leave, must make contributions required to purchase benefits under the Plan as provided below:

(a) The Compensation of a Participant who is on a paid leave of absence will be reduced in the same manner and in the same amount as if the Participant was not on leave.

(b) A Participant who is on unpaid leave of absence must:

(i) Make direct premium payments to the Plan each pay period. The amount of these payments will be determined in accordance with the Employer's leave of absence policy.

(ii) Make contributions to the Plan in any other manner that 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 must pay his or her share of the cost of this 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: (1) 29 CFR § 825.210(c), (2) the Employer's existing rules for payment by employers on other types of unpaid leave, or (3) 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 FMLA Leave under either of the following payment methods:

(i) Pre-pay method. Before a Participant begins his or her FMLA Leave, the Participant may pre-pay the amounts necessary to continue coverage during the FMLA Leave period.

(ii) Catch-up method. The Participant may pay for his or her share of the cost to continue coverage during the FMLA Leave after returning from FMLA Leave. This method of payment may be used only if the Employer and the Participant agree, before the FMLA Leave begins, 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 will be paid by the Participant when the Participant returns from FMLA Leave.

(iii) Notwithstanding anything to the contrary in this subsection (b), the Employer may use the "catch-up" method to recoup the Participant's share of the cost of continued coverage without obtaining the Participant's prior agreement if:

(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 the leave; or

(B) the Participant had previously elected to continue coverage during FMLA Leave failed to make required payments, and the Employer then elected to continue the coverage.

(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:

(i) Contributions may be made on a salary reduction basis under the payment method in section 4.05(a) to the extent the contributions are made from taxable compensation due the Participant during the FMLA Leave period.

(ii) Contributions under the "pre-pay" method (in section 4.05(b)(i)) may be made on a salary reduction basis from any taxable compensation, but if the FMLA Leave period spans two Plan Years, pre-payment on a salary reduction basis may not be made for the FMLA Leave period that falls in the second Plan Year.

(iii) Contributions under the "catch-up" method of payment (in section 4.05(b)(ii)) may be made on a salary reduction basis from any available taxable compensation after the Participant returns from FMLA Leave, as long as the Participant has not made any after-tax contributions towards that coverage.

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

(d) The payment methods for Participants on FMLA Leave will not be offered on terms less favorable than 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 into the Plan by reference.

If a new Employee becomes a Participant after the beginning of a Plan Year, the maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions made available to the Participant for the balance of the Plan Year will be prorated based on the number of Contribution Pay Periods remaining in the 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 consistent with the requirements of sections 105 and 125 of the Code. All other provisions of this Plan apply to and govern this Health Care Spending Account (HCSA) Plan, unless expressly contradicted by any provision of this Article or any applicable law or regulation.

5.02 Definitions

The following definitions apply within this Article V:

(a) *Authorized Representative* means an individual who has been authorized in writing by a claimant 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 is not the appointment of an *Authorized Representative* under these claims procedures.

(b) *Dependent* means an individual who is a Participant's *Dependent* as defined in section 152 of the Code, without regard to subsections (b)(1), (b)(2), and (d)(1)(B), or a Participant's child (as defined in section 152(f)(1)) who has not reached age 27 by the end of the applicable Plan Year.

(c) *Eligible Expense* means an expense that meets all of the following requirements:

(i) It is an expense for medical care as defined in section 213(d) of the Code, and is not a premium paid for other health insurance or plan coverage. However, an expense for a medicine or drug (including a medicine or drug that is available without a *Prescription*) is an *Eligible Expense* only if the Participant or *Dependent* received and submits a *Prescription* for the medicine or drug. Notwithstanding the preceding sentence, a Participant or *Dependent's* expense for insulin is an *Eligible Expense* with or without a *Prescription*.

(ii) It is incurred by the Participant, the Participant's Spouse or a *Dependent*.

(iii) It is not covered, paid for, or reimbursed under an insurance policy or any health plan other than this HCSA.

(iv) It is incurred during a Plan Year while the individual is a Participant under this Benefit Option.

(v) It is an expense for which the Participant has provided adequate substantiation.

For purposes of subparagraph (iv) above, an expense is "incurred" on the date the service is rendered or purchases are made from which the expense arises, regardless of when the Participant or the Participant's Spouse or *Dependent* was actually billed or paid for the expense. Expenses for supplies (such as eyeglasses or *Prescription* medications) are incurred on the date they are ordered, not when they are paid for or received. Certain dental procedures such as crowns, bridges, and root canal services are incurred on the date the procedure was initially started.

Orthodontic expenses are incurred in accordance with the following rules: Up to one-third of the total treatment expense is considered incurred on the date treatment begins. The remainder of the expenses are pro-rated over the course of the treatment, with each portion considered incurred on the date of the provider's regular billing cycle. If a Participant pays the entire expense before the end of the course of treatment, the expenses will be considered incurred on an equal monthly basis.

(d) *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 is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

5.03 Establishment of Health Care Spending Accounts

The City will establish a HCSA for each Plan Year for each Participant who elects to receive the HCSA Benefit Option for the Plan Year. Subject to section 5.04, a Participant's HCSA will be credited with the sum of: (a) the dollar amount the Participant elects to contribute to the HCSA for the Plan Year through Salary Reduction, and (b) the dollar amount of any Non-elective Employer Contributions allocated to a Participant's HCSA for the Plan Year. A Participant's HCSA will 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 his or her HCSA for any Plan Year is $2,550. The minimum amount that a Participant may elect to contribute for any Plan Year is $260.

(b) Except as provided in sections 4.05 and 5.05, Salary Reduction Contributions for the Plan Year must be contributed in substantially equal payments throughout the Plan Year. The number of payments must equal the number of Contribution Pay

Periods in the Plan Year (that are expected to occur with respect to an individual Participant), or portion thereof, during which the Employee is a Participant in this Plan. The payments must be made on each pay date while the individual is a Participant.

(c) Subject to section 5.06, the maximum benefit payable under this Plan to reimburse a Participant's *Eligible Expenses* is the sum of the Participant's Salary Reduction Contributions and Non-Elective Employer Contributions.

5.05 Limitation on Changes in Elections

A Participant may revoke his HCSA election and make a new HCSA election for the remainder of the Plan Year in accordance with the terms of section 3.07. If a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, will apply to *Eligible Expenses* incurred after the date the election is effective.

5.06 Limitations on Benefits

The HCSA Plan will not reimburse any Participant with respect to any Plan Year for any expense that:

(a) was not an *Eligible Expense*;

(b) was not incurred during the Plan Year;

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

(d) when taken together with prior reimbursements received by the Participant for that Plan Year, exceeds the amount of the Participant's HCSA election for the Plan Year in effect on the date the expense was incurred.

5.07 Claims for Reimbursement

(a) Except as provided in paragraph (b) below, a Participant must request reimbursement of *Eligible Expenses* by completing the appropriate application form that includes:

(i.) a written statement or confirmation from an independent third party stating that the *Eligible Expense* has been incurred and the amount of that expense;

(ii) 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

(iii) any other information that the Claim Administrator may require.

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

(b) Notwithstanding paragraph (a), certain *Eligible Expenses* incurred by individuals enrolled in a Health Plan Benefit Option may, through contractual arrangement, be automatically submitted to the Claim Administrator on the Participant's behalf without the Participant needing to submit a claim for reimbursement or provide additional substantiation.

(c) Claims will be paid directly to the Participant seeking reimbursement, and not to the provider of any services giving rise to the claim. Except for expenses that are automatically submitted as described in paragraph (b), 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 in which the *Eligible Expense* was incurred. Reimbursement will be made as soon as practical after the Participant has submitted complete documentation and the claim is approved by the Claim Administrator, but not 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 claimant will receive written notice of any claim denial within 30 days after receipt of the claim or any information requested by the Claim Administrator that is necessary to decide the claim. This period may be extended an additional 15 days, if required by matters beyond the Plan's control, if the Claim Administrator notifies the claimant of the circumstances that require the extension before the initial 15-day period expires.

5.09 Procedures for Appealing the Denial of a Claim

(a) A claimant has 60 days from the date he or she receives notification of a claim denial to appeal the denial to the Plan Administrator.

(b) The Plan Administrator will notify the claimant of its decision on the appeal no later than 30 days after the Plan Administrator receives the claimant's request for review of the denial. This period may be extended an additional 30 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 the claimant's behalf at any stage of these claims procedures. Once an *Authorized Representative* has been appointed, the Plan will direct all information and notices

to the *Authorized Representative*. The Plan will provide the claimant copies of 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

(i) A Participant who is on an unpaid FMLA Leave may choose to maintain his or her coverage under the HCSA Benefit Option for the duration of his or her FMLA Leave at the level and under the conditions that the coverage would have been provided if the Participant had continued in active employment. The Participant's right to maintain this coverage terminates when:

(1) the Participant terminates employment by either notifying the Employer that he or she does not intend to return from FMLA Leave or by failing to return from FMLA Leave when that leave is exhausted;

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

(3) the Participant fails to make a required contribution for coverage within the later of 30 days of the date due, or 15 days after the Employer notifies the Employee that his or her coverage will end for failure to make a required contribution. Coverage will end on the last day of the period for which the last contribution was made.

Participant contributions for continuing coverage under the HCSA must be made in accordance with the terms and conditions of section 4.06.

(ii) At the expiration of the FMLA Leave, a Participant whose coverage had ended, either because the Participant revoked his HCSA election pursuant to section 3.07 or because he or she failed to make required contributions, may resume coverage by making contributions to his or her HCSA. To the extent required by law, the Participant will be given the choice between:

(1) resuming coverage at the level in effect immediately prior to his or her FMLA Leave and making up any contributions that were not made during the FMLA Leave; or

(2) resuming coverage at a level that is reduced pro rata basis for the FMLA Leave period for which no contributions were made, with contributions due in the same monthly amount payable immediately before the FMLA Leave.

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

(iii) The Participant will not be reimbursed for *Eligible Expenses* incurred while coverage under the HCSA was not in effect.

(b) COBRA and USERRA

(i) 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 HCSA 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 will 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 will be treated as a Participant under the Plan. If continuation coverage is elected, coverage will be maintained and will *Eligible Expenses* be reimbursed as provided in this Article V.

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

(iii) If an election to continue coverage under this provision is not made, coverage under the HCSA Benefit Option will terminate on the last day of the pay period for which a required contribution was made. Reimbursement will be made only for *Eligible Expenses* incurred before the date coverage under the HCSA terminated, and only if a request for reimbursement is made as provided in sections 5.07 and 5.08. No reimbursement will exceed the amount of the Participant's election for the Plan Year on the day the *Eligible Expense* was incurred less prior reimbursements for that Plan Year.

(iv) The right of a Participant or other qualified beneficiary to continuation coverage under COBRA will terminate on the earlier of the last day of the Plan Year in which the qualifying event occurs, or the date on which one of the events specified in section 4980B(f)(2)(B)(ii) or (iii) of the Code occurs. The right of a Participant or beneficiary to continuation coverage under USERRA will terminate on the earlier of the date coverage is terminated for failure to pay a required premium, or the date on which the Employer is no longer required to maintain coverage under USERRA.

5.11 Forfeitures

(a) Any balance remaining in a Participant's HCSA for any given Plan Year on the last day of July immediately following the end of the Plan Year is forfeited as soon as practicable after the period of time necessary for the Administrator to give due consideration to all requests for reimbursement.

(b) If the total amounts credited to all Health Care Spending Accounts for a Plan Year exceed total reimbursements for that Plan Year, the excess amounts will not be retained by the Employer, but will 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 and nondiscriminatory basis; provided however, that no contributions will be returned or allocated to a Participant based on the amounts that Participant forfeited.

(c) If a Participant fails to present a reimbursement check for payment within 12 months of issuance, the benefits represented by that check are forfeited. These forfeited amounts will be applied toward the administrative expenses of the Plan or will 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 if necessary to prevent this Plan from being considered discriminatory under Code section 125 or Code section 105(h). Any action the Plan Administrator takes under this section will 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 sections 125 and 129 of the Code. All other provisions of this Plan apply to and govern this Dependent Care Spending Account (DCSA) Benefit Option, unless expressly contradicted by a provision of this Article or of any applicable law or regulation.

6.02 Definitions

The following definitions apply within this Article VI:

(a) *Applicable Statutory Limit* means the smallest of the following:

(i) the amount specified in section 6.04 as determined by the Participant's marital and filing status;

(ii) the Participant's earned income for the calendar year; or

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

For purposes of this definition, "earned income" has 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* and *DCSA Balance* mean the amount of contributions allocated to the Participant's DCSA 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 all of the following requirements:

(i) they are considered employment-related expenses as defined in section 21(b)(2) of the Code and the regulations issued under that section.

(ii) they are for services provided during the time the Employee was a Participant and elected to participate in this DCSA Benefit Option (regardless of when the Participant was actually billed or paid for those services), and that are provided while the Participant's election was in effect; and

(iii) they are expenses for which the Participant has provided adequate substantiation.

6.03 Establishment of Dependent Care Spending Account

The City will establish a DCSA for each Participant who elects to receive the DCSA Benefit Option for the Plan Year. A Participant's DCSA will be credited with the sum of: (a) the dollar amount the Participant elects to contribute to the DCSA through Salary Reduction, and (b) the dollar amount of any Non-elective Employer Contributions allocated to a Participant's DCSA for . The Participant's DCSA for each Plan Year will 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 for a married Participant who files a separate tax return). The minimum amount that a Participant may elect to contribute with respect to any Plan Year is $260.

6.05 Timing of Contributions

Except as permitted under section 3.07, Salary Reduction Contributions will be contributed in substantially equal installments during the Plan Year. The number of installments will 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 will 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 DCSA election and make a new DCSA election for the remainder of the Plan Year in accordance with the terms of section 3.07. If a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, will apply only to *Eligible Expenses* incurred after the date the election is effective.

(b) A Participant may revoke his DCSA 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*, and the Plan Administrator determines that the election clearly was based on a mistake of fact.

6.07 Limitations on Reimbursements

The DCSA will not reimburse any Participant in any Plan Year for any expense that:

(a) was not an Eligible Expense;

(b) was not incurred during the Plan Year;

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

(d) exceeds the lesser of the following:

(i) the amount of the Participant's election for the Plan Year in effect on the datethe expense was incurred reduced by the amount of prior reimbursements made for that Plan Year; or

(ii) the Participant's current *DCSA Balance*.

If the expense for which reimbursement is sought exceeds subparagraph (d)(ii) but not subparagraph (d)(i), the amount of the expense in excess of subparagraph (d)(ii) will be held for future reimbursement consideration within that Plan Year.

The Plan will not reimburse any Participant any amounts in excess of the Participant's *Applicable Statutory Limit*, when combined with the prior reimbursements to that Participant for that Plan Year.

6.08 Claims for Reimbursement

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

(i) a written statement from an independent third party stating that the Eligible Expense was incurred and the amount of the expense;

(ii) the name, address, and 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 that organization; and

(iii) any other information that the Claim Administrator may require.

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

(b) A Participant may submit proof of payment for a reimbursement claim at any time on or before the last day of July following the close of the Plan Year in which the Eligible Expense was incurred. Reimbursement will be made for Eligible Expenses as soon as practical after complete documentation is 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 claimant will receive written notice of any claim denial within 90 days after the receipt of the claim or any information requested by the Claim Administrator that is necessary to decide the claim. This period may be extended an additional 90 days if required by matters beyond the Plan's control, if the Claim Administrator notifies the claimant of the circumstances that require the extension before the initial 90-day period expires.

6.10 Procedures for Appealing the Denial of a Claim

(a) A claimant has 60 days from the date he or she receives notification of a claim denial to appeal the denial to the Plan Administrator.

(b) The Plan Administrator will notify the claimant of its decision on the appeal no later than 60 days after the Plan Administrator receives 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 Plan Administrator's decision is final.

6.11 Forfeitures

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

If the total amounts credited to all Dependent Care Spending Accounts for a Plan Year exceed total reimbursements for that 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 and nondiscriminatory basis; provided however, that no contributions will be returned or allocated to a Participant based on the amounts that Participant forfeited.

If 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 will be applied toward the administrative expenses of the Plan or will 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 in accordance with the terms of section 3.06.

6.13 Statements

The Plan will provide each Participant who has had contributions made to a DCSA during the Plan Year a written statement showing a reasonable estimate of the amount of *Eligible Expenses* reimbursed for that Plan Year, in accordance with applicable provisions of this Plan.

ARTICLE VII

Amendment or Termination

7.01 Right to Amend

The City Council may amend the Plan by resolution at any time; however, no amendment may have a retroactive adverse effect on any Participant, unless the City Council determines the amendment is necessary to comply with applicable law.

7.02 Right to Terminate

The City Council has the authority to terminate the Plan by resolution at any time in whole or in part; but, no such termination may prejudice any claim or benefit under the Plan that was incurred but not paid before the termination date.

ARTICLE VIII
Administration

8.01 Plan Administrator

The Plan Sponsor is the Plan Administrator. The Plan Administrator's principal duty is to see that the Plan is administered 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 has 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 include, but are not 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. The Plan Administrator may change the cost at any time before or during a Plan Year without prior notice to Participants or the Employer.

(c) To make and enforce the rules and regulations it deems necessary or proper to efficiently administer the Plan, including establishing any claims procedures that may be required by law.

(d) To interpret the Plan. The Plan Administrator's good faith interpretation is final and conclusive on all persons claiming benefits under the Plan.

(e) To decide all questions concerning the Plan, including the eligibility of any person to participate in the Plan.

(f) To appoint agents, counsel, accountants, consultants, and other persons required to assist in administering the Plan.

(g) To allocate and delegate the Plan Administrator's 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 delegation is set out in a written instrument signed by the Plan Administrator and the designated party.

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

(i) To notify the Participants in writing of any substantive amendment to the Plan, termination of the Plan, or change in benefits available under the Plan.

The powers and duties allocated to the Plan Administrator and described in this section apply only with respect to a claim arising under the Benefit Options or the administration of the Benefit Options to the extent that that power or duty is not allocated (either expressly or by implication) to the individuals 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 the records under the Plan that pertain to that Participant 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 will 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 will perform its duties as the Plan Administrator, and in its sole discretion will determine appropriate courses of action, in light of the purpose for which this Plan is established and maintained. The Plan Administrator has the sole discretion to 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. The Plan Administrator's construction of the terms of the Plan will be final and legally binding on all parties, if there is a rational basis for that construction.

Any interpretation of the Plan or other action of the Plan Administrator is subject to review only if the interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator must be based only on the evidence presented to or considered by the Plan 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 must provide the Plan Administrator the information and evidence, and must sign the documents, that the Plan Administrator reasonably requests in administering the Plan.

9.02 Limitation of Rights

The establishment or amendment of this Plan, and the payment of any benefits under the Plan, do not confer upon any Participant or other person any legal or equitable right against the Plan Sponsor, except as provided in this plan document.

9.03 Governing Law

This Plan must be construed, administered and enforced according to the laws of the State 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 this Plan incapable of receiving or disbursing that amount by reason of minority, death, illness, 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 the amount directly for the comfort, support, and maintenance of the person.

(b) Reimburse any person for any support previously supplied to the person entitled to receive the payment.

(c) Pay the 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 the amount, including without limitation, any relative who has undertaken, wholly or partially, the expense of that person's comfort, care, and maintenance, or any institution caring for that person. The Plan Administrator may, in its discretion, deposit any amount due to a minor to the minor's credit in any savings or commercial bank chosen by the Plan Administrator.

9.05 Lost Payee

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

9.06 No Guarantee of Tax Consequences

Notwithstanding anything in this plan document to the contrary, the Employer does not ensure or guarantee that any amounts paid to a Participant under 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 is 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 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 Employer's general assets or otherwise provided by a third party insurance company with whom the Plan Administrator has contracted to provide certain benefits. 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, the Participant must 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 those payments. This indemnification and reimbursement will 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 that 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 10.04, a 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 the Employer only for the purpose of enabling the Employer to perform administrative functions related to the treatment, payment, and health care operations of the Health Plan (as defined in 45 CFR § 164.501).

The Employer will not 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 will:

(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 agent to whom it provides Protected Health Information received from the Health Plan, including a subcontractor, agrees 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 of the Employer's other benefit or employee benefit plans.

(d) Report to the Health Plan any use or disclosure of the information that it becomes aware of that is inconsistent with the permissible uses or disclosures.

(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 the Health Plan's compliance 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 this information when no longer needed for the purpose for which disclosure was made, except that, if the 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 the adequate separation between the Health Plan and Employer required by 45 CFR § 504(f)(2)(iii).

(k) Report the discovery of a breach of unsecured Protected Health Information (as defined in 45 CFR §1 64.402) to the covered individual, the media and the Secretary of the Department of Health and Human Services, in accordance with 45 CFR § 164.404, 45 CFR § 164.406, and 45 CFR § 164.408.

(l) If the Employer receives electronic Protected Health Information, as defined in 45 CFR § 160.103, it will:

(i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic Protected Health Information that it creates, receives, maintains, or transmits on the Plan's behalf;

(ii) 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;

(iii) ensure that any agent to whom it provides electronic Protected Health Information , including a subcontractor, implements reasonable and appropriate security measures to protect the electronic Protected Health Information; and

(iv) 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), the following conditions apply:

(a) The Plan may disclose only to employees employed in the Employer's human resources department 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 10.03(a) will be restricted to the plan administration functions that the Employer performs for the Health Plan.

(c) An individual described in section 10.03(a) who fails to comply with the Plan provisions relating to the use and disclosure of Protected Health Information will be subject to disciplinary action under the Employer's established policies and procedures.

10.04 Certification

The Health Plan will disclose Protected Health Information to an Employer only after receiving 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 will not disclose Protected Health Information to the Employer as otherwise permitted in this Plan, unless the statement required by 45 CFR § 164.520(b)(1)(iii)(C) is included in the appropriate notice.

To record the adoption of the Plan, the City's duly authorized officer has signed this document effective July 1, 2015.

CITY OF SAN DIEGO

____
Signature

____
Scott Chadwick

____
Chief Operating Officer

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. MEA Sharp HMO Medical
5. POA Medical
6. Local 145 Medical
7. Concordia Plus DHMO Dental
8. Concordia Preferred DPO Dental
9. MEA Dental
10. Local 127 Dental
11. Blue Shield of CA / MESVision
12. MEA Vision
13. Health Care Spending Account
14. Dependent Care Spending Account
15. Basic Term Life Insurance with AD&D
16. City of San Diego 401(k) Plan

Item 332 - Attachment B
FY 2015 - 2016 CITY FBP CREDITS

BARGAINING UNIT	BIWEEKLY	ANNUAL	MONTHLY
MEA	$329.04	$8,555	$712.92
Teamsters 911	$396.58	$10,311	$859.25
Local 127			
Waive	$261.77	$6,806	$567.17
Employee only	$300.24	$7,806	$650.50
Employee & Spouse/Domestic Partner	$346.77	$9,016	$751.34
Employee & Children	$321.39	$8,356	$696.34
Employee & Spouse/Domestic Partner & Children	$386.77	$10,056	$838.00
Local 145*			
Waive	$67.31	$1,750	$145.84
Employee only	$314.62	$8,180	$681.67
Employee & Spouse/Domestic Partner	$555.89	$14,453	$1,204.42
Employee & Children	$453.97	$11,803	$983.59
Employee & Spouse/Domestic Partner & Children	$632.58	$16,447	$1,370.59
POA *			
Waive	$292.50	$7,605	$633.75
Employee only	$382.39	$9,942	$828.50
Employee & Spouse/Domestic Partner	$476.35	$12,385	$1,032.09
Employee & Children	$458.43	$11,919	$993.25
Employee & Spouse/Domestic Partner & Children	$642.31	$16,700	$1,391.67
POA * Eight Plus Years of Service			
Waive	$404.04	$10,505	$875.42
Employee only	$493.93	$12,842	$1,070.17
Employee & Spouse/Domestic Partner	$587.89	$15,285	$1,273.75
Employee & Children	$569.97	$14,819	$1,234.92
Employee & Spouse/Domestic Partner & Children	$753.85	$19,600	$1,633.34
POA Lieutenants and Captains*			
Waive	$407.89	$10,605	$883.75
Employee only	$497.77	$12,942	$1,078.50
Employee & Spouse/Domestic Partner	$591.74	$15,385	$1,282.09
Employee & Children	$573.81	$14,919	$1,243.25
Employee & Spouse/Domestic Partner/Children	$757.70	$19,700	$1,641.67
POA Lieutenants and Captains* 8 plus YOS			
Waive	$519.43	$13,505	$1,125.42
Employee only	$609.31	$15,842	$1,320.17
Employee & Spouse/Domestic Partner	$703.27	$18,285	$1,523.75
Employee & Children	$685.35	$17,819	$1,484.92
Employee & Spouse/Domestic Partner/Children	$869.24	$22,600	$1,883.34
DCAA *			
Waive	$242.00	$6,292	$524.34
Employee only	$384.35	$9,993	$832.75
Employee & Spouse/Domestic Partner	$519.39	$13,504	$1,125.34
Employee & Children	$477.62	$12,418	$1,034.84
Employee & Spouse/Domestic Partner & Children	$533.50	$13,871	$1,155.92
Unrepresented/Unclassified Salaried *			
Waive	$262.58	$6,827	$568.92
Employee only	$385.70	$10,028	$835.67
Employee & Spouse/Domestic Partner	$501.00	$13,026	$1,085.50
Employee & Children	$478.97	$12,453	$1,037.75
Employee & Spouse/Domestic Partner & Children	$562.35	$14,621	$1,218.42
Unrepresented/Unclassified Hourly *			
Waive	$120.93	$3,144	$262.00
Employee only	$244.04	$6,345	$528.75
Employee & Spouse/Domestic Partner	$359.35	$9,343	$778.59
Employee & Children	$337.31	$8,770	$730.84
Employee & Spouse/Domestic Partner & Children	$420.70	$10,938	$911.50

* Fulltime Allotment - Prorated if 3/4 or 1/2 time

Passed by the Council of The City of San Diego on APR 21 2015, by the following vote:

Councilmembers	Yeas	Nays	Not Present	Recused
Sherri Lightner	☒	☐	☐	☐
Lorie Zapf	☒	☐	☐	☐
Todd Gloria	☒	☐	☐	☐
Myrtle Cole	☒	☐	☐	☐
Mark Kersey	☒	☐	☐	☐
Chris Cate	☒	☐	☐	☐
Scott Sherman	☒	☐	☐	☐
David Alvarez	☐	☐	☒	☐
Marti Emerald	☒	☐	☐	☐

Date of final passage MAY 05 2015.

(Please note: When a resolution is approved by the Mayor, the date of final passage is the date the approved resolution was returned to the Office of the City Clerk.)

AUTHENTICATED BY:

KEVIN L. FAULCONER
Mayor of The City of San Diego, California.

ELIZABETH S. MALAND
City Clerk of The City of San Diego, California.

(Seal)

By [signature], Deputy

Office of the City Clerk, San Diego, California

Resolution Number R- 309630