ROCKLIN
CALIFORNIA

CITY OF ROCKLIN
SECTION 125
CAFETERIA PLAN DOCUMENT

Adopted February 25, 1992
Amended and Restated, Effective January 1, 2022

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SECTION 125 CAFETERIA PLAN ADOPTION AGREEMENT

The City of Rocklin (Employer) hereby adopts the amended and restated Section 125 Cafeteria Plan for those Employees who shall qualify as Participants hereunder. The City of Rocklin hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	City of Rocklin CA
Address:	3970 Rocklin Road Rocklin, CA 95677
Employer Identification Number:	94-60000408
Nature of Business:	
Name of Plan:	City of Rocklin CA Flexible Benefit Plan
Plan Number:	501

B. EFFECTIVE DATE

Amendment and Restatement Effective Date:	January 1, 2022

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable.

Length of Service:	Effective upon hire date.
Eligibility:	Eligible employees include active employees and retired persons who receive an early stipend or other W-2 taxable compensation from the City
Minimum Hours:	All employees with 40 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum of 18.0 years of age.

D. PLAN YEAR

The Plan Year is January 1 through December 31.

E. CONTRIBUTIONS

Non-Elective Contributions

Employer furnishes non-elective contributions for medical insurance (health/dental/vision) premiums, long-term disability insurance premiums, and life and accidental death and dismemberment (AD&D) insurance premiums, and an additional flex credit which may be used for certain benefits available in the Plan.

Elective Contributions (Salary Reduction)

The amount of the Employer's contribution will be set by the Employer each Plan Year in a uniform and non-discriminatory manner, in accord with collective bargaining agreements and City policy. If the Employer's contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash, except that the Participant may be eligible for a taxable cash payment due to the Employee's declination of health insurance coverage/full family health insurance coverage, in accordance with the applicable collective bargaining agreement or City policy. If the employee opts out of health insurance, the Employee must provide certification of other group health insurance coverage to receive the taxable cash payment.

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. AVAILABLE BENEFITS

Each of the following components should be considered benefits that comprise this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy, policies, contracts and/or enrollment documents. See Section V of the Plan Document)

   Employer contracts with CalPERS for group health insurance, and provides a direct contribution to Employees' health insurance premiums in an amount established by collective bargaining agreement or City policy. In accordance with and to the extent required by the Patient Protection and Affordable Care Act, any amendments thereto and lawful guidance published thereunder, Employer shall automatically enroll new full-time eligible Employees in one of the group health plans offered (subject to any waiting periods) and continue the enrollment of current Participants in a group health plan. The Employer or Administrator shall provide adequate notice to Employees of such automatic enrollment and the opportunity for an Employee to opt out of any coverage in which the Employee was enrolled.

Participant is responsible for payment of the difference in any monthly premium cost for the medical insurance plan and coverage level selected that exceeds the Employer's contribution (direct or flex credit).

2. **Group Dental/Vision Insurance** - The terms, conditions, and limitations for the Dental/ Vision Insurance will be as set forth in the applicable insurance policies, contracts, and/or enrollment documents, and are further discussed in Section VI of the Plan Document. (*See* Section VI of the Plan Document)

   Employer provides a direct contribution for Employees' dental and vision insurance coverage in an amount established by collective bargaining agreement or City policy. Participant is responsible for payment of the difference in any monthly premium cost for the insurance plan and coverage level selected that exceeds the Employer's contribution (direct or flex credit).

3. **Long-term Disability Insurance** --The terms, conditions, and limitations for the insurance will be as set forth in the applicable insurance policy and/or enrollment documents. (See Section VII of the Plan Document)

   Employer provides a direct contribution for Employee Long-Term Disability Insurance coverage in an amount established by collective bargaining agreement, contract, or City policy.

4. **AD&D and Life Insurance** under Section 79 of the Internal Revenue Code. The terms, conditions, and limitations for the insurance will be as set forth in the insurance policy, policies, contracts and/or enrollment documents. (See Section VIII of the Plan Document)

   Employer provides a direct contribution for employee AD&D and Group Life Insurance coverage in an amount established by collective bargaining agreement, contract and/or City policy. City paid life insurance in excess of $50,000 will be treated as taxable income to the Employee. Participant may elect supplemental AD&D or Life Insurance benefits. Participant is responsible for the monthly premiums associated with any such plans. Participant may elect to use the Employer provided flex credit (if any) and/or may elect to enter into a salary reduction agreement for the supplemental benefits.

5. **Dependent Care Assistance Benefit** -- The terms, conditions, and limitations for the Dependent Care Assistance Benefit will be asset forth in Section IX of the Plan Document and described below:

   This benefit is intended to comply with the provisions of Internal Revenue Code section 129 with respect to dependent care assistance and therefore, will be deemed to be automatically amended to comply with all legislative changes to and valid regulations promulgated under, the Internal Revenue Code.

Participant may elect this benefit through application of the Employer's flex credit (if any) and/or by entering into a salary reduction agreement. In no event can the Participant's maximum contribution per Plan Year exceed the limit set forth in the Internal Revenue Code and/or regulations.

6. **Medical Expense Reimbursement Benefit**-- The terms, conditions, and limitations for the Medical Expense Reimbursement Benefit will be as set forth in Section X of the Plan Document and described below:

   This benefit is intended to comply with the provisions of the Internal Revenue Code sections 105 and 106 and therefore, will be deemed to be automatically amended to comply with all legislative changes to and valid regulations promulgated under, the Internal Revenue Code.

   Participant may elect this benefit by entering into a salary reduction agreement. In no event can Participant's maximum contribution per Plan Year exceed the limit set forth in the Internal Revenue Code and/or regulations.

   Grace Period: Yes.

   Carryover: No.

7. **Other Available Supplemental Program Benefits**

   a. Employer may offer other elective program benefits, to include but not be limited to the following. Additional elective program benefits may be added to this Plan without requiring amendment. Employer reserves the right to add or remove elective program benefits each Plan Year.

      (i) Accident Insurance.

      (ii) Cancer Coverage

      (iii) Short-Term Disability Insurance

      (iv) Critical Illness Insurance

      (v) Hospital Indemnity

   b. The terms, conditions, and limitations for each of the supplemental program benefits will be as set forth in the insurance policy, contract and/or enrollment documents.

   c. Participants may elect these supplemental benefits through application of the Employer's flex credit (if any) and/or by entering into a salary reduction agreement.

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Internal Revenue Code of 1986 (as amended), and the laws of the State of California. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

THIS DOCUMENT IS NOT COMPLETE WITHOUT SECTIONS I THROUGH XIV, SET FORTH BELOW AND INCORPORATED HEREWITH BY REFERENCE.

This Plan is hereby adopted _____.

City of Rocklin CA
CITY OF ROCKLIN

Signed By: _____

Title: _____

SECTION 125 CAFETERIA PLAN

SECTION I - PURPOSE

The Employer amends and restates the City of Rocklin Section 125 Cafeteria Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to amend and restate this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II - DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator.** The Employer unless another has been designated in writing by the Employer as Administrator.

2.02 **Beneficiary -** Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.03 **Carryover -** The amount remaining unused as of the end of the Plan Year in the Medical Reimbursement flexible spending account.

2.04 **Code -** Internal Revenue Code of 1986, as amended.

2.05 **Dependent -** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom Code Section

152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full- time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.06 Effective Date - The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.07 **Elective Contribution -** The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.08 **Eligible Employee -** Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.

2.09 **Employee -** Any person employed by the Employer on or after the Effective Date.

2.10 **Employer -** The City of Rocklin.

2.11 **Employer Contributions** Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.

2.12 **Entry Date -** The date that an Employee is eligible to participate in the Plan.

2.13 **ERISA -** The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).

2.14 **Fiduciary -** The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.

2.15 **Highly Compensated -** Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.

2.16 **HIPAA -** The Health Insurance Portability and Accountability Act of 1996, as amended.

2.17 **Insurer -** Any insurance company that has issued a policy pursuant to the terms of this Plan.

2.18 **Key Employee -** Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.19 **Non-Elective Contribution -** A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.

2.20 **Participant -** An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.

2.21 **Plan -** The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.

2.22 **Plan Year -** The Plan Year as specified in Item D of the Adoption Agreement.

2.23 **Policy -** An insurance policy issued as a part of this Plan.

2.24 **Recordkeeper -** The person or entity designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Benefit and/or the Dependent Care Reimbursement Benefit.

SECTION III - ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during the open or special enrollment period, or within 60 days of appointment, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. For CalPERS health plans, CalPERS also allows late enrollment, with a 90-day waiting period. A Participant's Election Form shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: Except as otherwise provided in this Plan, a Participant will automatically cease to be a Participant as a result of the occurrence of the earliest of the following events on (i) the first day of the month in which the event occurs, if it occurs on the first day of the month; or (ii) the last day of the month in which the event occurs if the event does not occur on the first day of the month.

A. Participant’s termination of employment by death, disability, retirement or other separation from service;

B. Participant ceases to be an eligible Employee under the terms of the Plan;

C. The Employee ceases to be a Participant pursuant to the leave of absence section 3.04, below;

D. The date of termination of the Plan.

Termination of participation shall not affect the Participant's or the Participant's Beneficiary's right to claim benefits for expenses incurred prior to such termination. However, no additional expenses incurred after such termination of participation shall be covered by the Plan.

3.04 QUALIFYING FAMILY OR MILITARY LEAVE: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) or the California Family Rights Act (CFRA), to the extent required by the FMLA or CFRA, the Employer will continue to maintain the Participant's existing coverage under those group health plans that are subject to the provisions of the FMLA or CFRA. Upon return from FMLA/CFRA leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his or leave, or as otherwise required by the CFRA or FMLA. If the Employee opts to continue coverage, the Employee may pay his or her Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he or she receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his or her Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his or her pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him or her (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA or CFRA. An Employee who is absent from the Employee's position of employment by reason of service in the uniformed services may elect to continue such coverage as and to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as it may be amended by subsequent federal legislation.

SECTION IV - CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year, during the open enrollment period, revising the rate of his or her contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his or her employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

A. Change in Status. A Participant may change or revoke his or her election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

   a. Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;

   b. Change in number of Dependents, including birth, adoption, placement for adoption, and death;

   c. Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his or her previous election. If the

Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;

d. Change in dependent eligibility. Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and

e. Change in residence of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

B. Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

C. Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident

or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

D. Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

E. Family Medical Leave Act/California Family Rights Act. If an Employee is taking leave under the rules of the Family Medical Leave Act or the California Family Rights Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

F. COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his or her pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

G. Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.05(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

H. Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, under the Employer's Plan if both of the following conditions are met:

    a. The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

b. The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

I. Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage under the Employer's Plan if both of the following conditions are met:

a. The Participant is eligible for a Special Enrollment Period (as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

b. The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

J. CalPERS Health Plans. Employees who decline or cancel enrollment in CalPERS health plans may be allowed to enroll or re-enroll, pursuant to CalPERS rules and regulations, with a 90-day waiting period.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Benefit, or may not be modified with respect to the Medical Expense Reimbursement Benefit during the Plan Year.

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes applicable to Plan Benefits except the flexible spending accounts (medical reimbursement, dependent care), group health, dental, and vision insurance coverage as follows:

A. Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a

corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of an elective benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be adjusted, upon written notice to Participant.

B. Significant Curtailment of Coverage.

   a. With no loss of coverage. If the coverage under an elective benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

   b. With loss of coverage. If there is a significant curtailment of coverage with loss of coverage of an elective benefit package, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

C. Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

D. Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan will not be a cash benefit under the Plan payable to the Participant. The sole exception is the cash payment that may be available to an Employee who declines health insurance coverage/full family health insurance coverage, in accordance with the

applicable collective bargaining agreement or City policy. If an employee declines health plan coverage, the Employee must provide certification of other group health insurance coverage to receive the opt-out payment, which will be treated as taxable income as indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V - GROUP MEDICAL INSURANCE BENEFIT

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Item C of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1-7) of the Adoption Agreement, the CalPERS contract, and/or other CalPERS documents pertaining to the benefits.

5.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the CalPERS contract, and/or other CalPERS documents pertaining to the benefits.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant, and by Participant pursuant to a salary reduction agreement, as provided for in Item E of the Adoption Agreement.

5.08 COMPLIANCE WITH LAW: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the law, including but not limited to the Uniformed Services Employment and Reemployment Rights Act of 1994, the Family Medical Leave Act, and the California Family Rights Act, as amended.

SECTION VI - GROUP DENTAL AND VISION BENEFIT

6.01 PURPOSE: This benefit provides dental and vision insurance benefits to Participants.

6.02 ELIGIBILITY: Eligibility will be as required in Item C of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available will be as defined in Item F(2) of the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Benefits shall be as described in the Adoption Agreement, applicable policies, contracts and enrollment documents.,.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant, and by Participants, as provided for in Item E of the Adoption Agreement.

SECTION VII - LONG-TERM DISABILITY INSURANCE BENEFIT

7.01 PURPOSE: This benefit provides long-term disability insurance benefits to Participants and may as provided for in Item F(3) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item C of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(3) of the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the long-term disability insurance benefit are described in the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

7.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VIII - ACCIDENTAL DEATH AND DISMEMBERMENT, GROUP AND INDIVIDUAL LIFE INSURANCE BENEFIT

8.01 PURPOSE: This benefit provides group life and AD&D insurance benefits to Participants and may provide certain individual policies as provided for in Item F(4) of the Adoption Agreement.

8.02 ELIGIBILITY: Eligibility will be as required in Item C of the Adoption Agreement.

8.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(4) of the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

8.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the AD&D and life insurance benefits are described in the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

8.05 SECTION 105, 106, 79 PLAN: It is the intention of the Employer that the premiums Employer pays for the group life insurance benefits described in Item F(4) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. Group life insurance benefits provided by Employer in excess of $50,000 will be treated as taxable income. It is also the intention of the Employer that the individual life and AD&D premiums paid for such benefits shall be eligible for exclusion from the gross income of the Participants as provided in Code Sections 104, 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

8.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant, and by Participants, as provided for in Item E of the Adoption Agreement.

SECTION IX - FLEXIBLE SPENDING ARRANGEMENT- MEDICAL EXPENSE REIMBURSEMENT BENEFIT

9.01 PURPOSE: The Flexible Spending Arrangement, Medical Expense Reimbursement Benefit is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 9.04) that are not reimbursed under an insurance plan, or otherwise. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item C of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

A. Accounts. The Administrator, or if appointed, the Reimbursement Recordkeeper, shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

B. Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(6) of the Adoption Agreement.

C. Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose with an original bill or other proof of the expense forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant.

D. Funding. The funding of the Flexible Spending Arrangement, Medical Reimbursement Benefit shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants pursuant to a salary reduction agreement. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Benefit plan.

E. Use or Lose. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall not be carried over from one Plan Year to the next Plan Year, however, this Plan provides a Grace Period, see Section 9.05, below.

With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 9.03(E) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his or her termination date regardless if such Participant has any amounts of Employer Contributions remaining to his or her credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

At the Employer's option, and to the extent allowed by the Internal Revenue Code and regulations, forfeited funds may be used to cover overpayments to other Participants, used for payment of reasonable plan administration expenses, used to reduce employee salary reduction amounts for the immediately following Plan Year, returned to Participants in the form of taxable cash, or returned to the Employer.

F. COBRA. To the extent required by Section 4980B of the Code ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

G. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Benefit plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly

compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

H. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Benefit, shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses To the extent contributions with respect to this Medical Expense Reimbursement Benefit are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Benefit by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

I. Compliance with Applicable Law. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with applicable law, including but not limited to provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, the Family Medical Leave and the California Family Rights Act, as amended.

J. Proration of Limit. The maximum contribution amount specified in Section F.6 of the Adoption Agreement shall be prorated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such maximum contribution amount will be prorated by dividing the annual maximum contribution amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

K. Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Benefit plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Benefit plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Benefit plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

9.04 ELIGIBLE MEDICAL EXPENSES:

A. Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his or her Dependents (subject to the restrictions in Sections 9.04(B) and (C)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan or otherwise. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan.

B. Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

C. Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.05(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.05(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 9.04(B)).

9.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply.

9.05.1 Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

A. If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major

medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

B. If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

9.05.2 Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (A) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

9.05.3 Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

A. First, upon identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

B. Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

C. Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

D. If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

9.05.3.1 Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in Rev. Rul. 2003-43, and this Section 9.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

9.06 GRACE PERIOD: Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Benefit plan from the

immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

9.07 QUALIFIED RESERVIST DISTRIBUTIONS: Notwithstanding anything in the Plan to the contrary, an individual who, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), is ordered or called to active duty for a period in excess of 179 days or for an indefinite period may elect to receive a distribution of all or a portion of the unused Elective Contributions in his or her Account relating to the Medical Expense Reimbursement Benefit plan if the distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year that includes the date of such order or call. If the distribution is for the entire amount of unused Elective Contributions available in the Medical Expense Reimbursement Plan, then no additional reimbursement requests will be processed for the remainder of the Plan Year.

SECTION X - DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENT

10.01 PURPOSE: The Dependent Care Flexible Spending Arrangement is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section X shall be construed in a manner consistent with that intention.

10.02 ELIGIBILITY: The eligibility provisions are set forth in Item C of the Adoption Agreement.

10.03 TERMS, CONDITIONS, AND LIMITATIONS:

A. Accounts. The Administrator, or if appointed, the Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

B. Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(5) of the adoption agreement.

For purpose of this Section X, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 10.04(A)(b) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents, or as otherwise established by the Internal Revenue Code or regulations.

C. Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose with an original bill or other proof of the expense from an independent third party. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the

claims procedure set forth in Section XIII.

D. Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants pursuant to a salary reduction agreement. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

Use or Lose. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and shall not be carried over from one Plan Year to the next Plan Year. At the Employer's option, and to the extent allowed by the Internal Revenue Code and regulations, forfeited funds may be used for payment of reasonable plan administration expenses, used to reduce employee salary reduction amounts for the immediately following Plan Year, and/or returned to Employer.

E. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129.

10.04 DEFINITIONS:

A. "Dependent" (for purposes of this Section X) means any individual who is:

a. a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

b. a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Benefit plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

B. "Dependent Care Center" (for purposes of this Section X) shall be a facility which:

a. provides care for more than six individuals (other than individuals who reside at the facility);

b. receives a fee, payment, or grant for providing services for any of the

individuals (regardless of whether such facility is operated for profit); and

c. satisfies all applicable laws and regulations of a state or unit of local government.

C. "Eligible Dependent Care Expenses" (for purposes of this Section X) shall mean expenses incurred by a Participant which are:

a. incurred for the care of a Dependent of the Participant or for related household services;

b. paid or payable to a Dependent Care Service Provider; and

c. incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

D. "Dependent Care Service Provider" (for purposes of this Section X) means:

a. a Dependent Care Center, or

b. a person who provides care or other services described in Section 10.04(B) and who is not a related individual described in Section 129(c) of the Code.

SECTION XI - SUPPLEMENTAL PROGRAM BENEFITS

11.01 PURPOSE: This benefit provides supplemental accident and health benefits to Participants.

11.02 ELIGIBILITY: Eligibility will be as required in Item C of the Adoption Agreement.

11.03 DESCRIPTION OF BENEFITS: The supplemental elective benefits available under this Plan include but are not limited to the following: accident insurance, cancer coverage, short term disability, critical illness insurance, and hospital indemnity. The benefits are more specifically described in Item F(7) of the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

11.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of these supplemental program benefits are described in the Adoption Agreement, and the applicable contracts, policies, and enrollment documents.

11.05 SECTION 105, 106 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(7) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104, 105 and 106, and all provisions of these benefit programs shall be construed in a manner consistent with that intention.

11.06 CONTRIBUTIONS: Contributions for the supplemental benefit programs will be provided by the Employer on behalf of a Participant, or by Participants, as provided for in Item E of the Adoption Agreement

SECTION XII AMENDMENT AND TERMINATION

12.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

12.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XIII - ADMINISTRATION

13.01 NAMED FIDUCIARIES: The named fiduciary is the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.

13.02 APPOINTMENT OF RECORDKEEPER AND/OR THIRD-PARTY ADMINISTRATOR: The Employer may appoint a Recordkeeper and/or a third-party administrator delegating the authority and responsibility of performing recordkeeping and/or administrative services, or other ministerial duties under this Plan. The Recordkeeper and/or administrative services provider shall serve at the pleasure of, and may be removed by, the Employer without cause. If a third-party is appointed to provide recordkeeping, administrative services, or other ministerial duties for the Flexible Spending Arrangements, the Employer may establish reasonable fees for such administrative services, which may be charged to Participants in the Flexible Spending Arrangements.

13.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

A. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

B. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code the regulations promulgated thereunder, and any applicable California laws.

C. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

13.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Employer as Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

13.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct.

13.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

13.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

13.08 CLAIM FOR BENEFITS & APPEALS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit. The claims procedures, including the time frames for submitting claims, are set forth in the governing documents for each Benefit program.

13.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan.

13.09.1 Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 13.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be

reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

13.09.2 Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review, unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

13.09.3 Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

13.10 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

13.11 PROTECTED HEALTH INFORMATION. The provisions of this Section XIII will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and

use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Administrator and if applicable, the third-party administrator and/or Recordkeeper will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractor to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Administrator respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan Administrator any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Administrator still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, “PHI” is “Protected Health Information” as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of “Protected Health Information” in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIV - MISCELLANEOUS PROVISIONS

14.01 INSURED BENEFITS, FUNDING, AND BENEFIT PAYMENTS. The benefits provided under the Plan through contracts shall be provided by insurance companies, health care service plans or other service providers with which the Employer or the Administrator on behalf of the Plan, contracts from time to time in order to provide such benefits under the Plan. Employer shall have no obligation under this Plan, with respect to benefits provider under contract, beyond the payment of the Employer's share of the appropriate premium and the remittance of each eligible Employee's share of the premium to the appropriate third party to the extent that such premiums have been paid to the Employer by the Employee or withheld from the Employee's wages pursuant to the terms of this Plan. The benefits provided under a contract shall be funded through and benefits provided under and in accordance with the provisions of the contracts. Such contracts shall be maintained by Employer or the Administrator, on behalf of the Plan. The benefits provided under a contract shall be paid by the insurance companies, health care service plans or other service providers in accordance with the provisions of the contracts. The Employer shall not be responsible for the validity of any contract or any policy issued by any provider of coverage, or for the failure on the part of any provider of coverage, other than the Employer, to make payments provided for under any such contract, or for the action of any person that may delay or render void or unenforceable, in whole or in part, any such contract.

14.02 COMPLIANCE WITH FEDERAL AND STATE LAW. Each Benefit program will comply to the extent possible with the requirement of all applicable laws.

14.03 INABILITY TO LOCATE PAYEE: If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.04 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

14.05 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

14.06 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

14.07 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

14.08 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

14.09 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

14.10 CONSTRUCTION OF THE LAW. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the Internal Revenue Code of 1986 (as amended), and the laws of the State of California. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.