City of Manhattan Beach

Section 125 Flexible Benefits Plan

Restatement Effective January 1, 2018

CITY OF MANHATTAN BEACH SECTION 125 FLEXIBLE BENEFITS PLAN

ARTICLE I. Introduction

1.1 Establishment of Plan. City of Manhattan Beach ("City") hereby amends and restates the City Section 125 Flexible Benefits Plan, upon approval by City Council, effective for plan years beginning January 1, 2018. Capitalized terms shall have the meanings set forth in Article II unless defined elsewhere in the Plan.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions under the Medical Insurance Plan on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to a Health FSA for reimbursement of certain Medical Care Expenses, and/or to a Dependent Care FSA for reimbursement of certain Dependent Care Expenses.

1.2 Legal Status. This Plan is intended to qualify as a cafeteria plan under Code § 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code § 105, with the reimbursed Medical Care Expenses eligible for exclusion from participating Employees' gross income under Code § 105(b). The Dependent Care FSA Component is intended to qualify as a dependent care assistance program under Code § 129, with the reimbursed Dependent Care Expenses eligible for exclusion from participating Employees' gross income under Code § 129(a).

The Health FSA Component and the Dependent Care FSA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of HIPAA and COBRA.

ARTICLE II. Definitions

2.1 Definitions.

Account(s) means the Health FSA Accounts and the Dependent Care FSA Accounts described in Section 7.5 for Health FSAs, and Section 8.5 for Dependent Care FSAs.

Benefits means the Premium Payment Benefits, the Health FSA Benefits, and the Dependent Care FSA Benefits offered under the Plan.

Benefit Package Option means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an HMO or a PPO option under an accident or health plan).

Change in Status means any of the events described below, as well as any other events included in subsequent changes to Code § 125, or regulations or guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under applicable law and under this Plan:

(a) ***Legal Marital Status***. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) ***Number of Dependents***. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) ***Employment Status***. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

(d) ***Dependent Eligibility Requirements****.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) ***Change in Residence****.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Committee means the Benefits Committee appointed by the City.

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 403(b) or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

Component(s) means one or more of the following: the Dependent Care FSA Component, the Health FSA Component, or the Premium Payment Component.

Contribution(s) means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, and Section 8.2 for Dependent Care FSA Benefits.

Dependent Care FSA means dependent care assistance flexible spending account program.

Dependent Care FSA Account means the account described in Section 8.5.

Dependent Care FSA Benefits has the meaning described in Section 8.1.

Dependent Care FSA Component means the component of this Plan described in Article VIII.

Dependent means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined in Code § 105(b), (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the Dependent Care FSA Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 8.3.

Earned Income shall have the meaning given such term in Code § 129(e)(2).

Effective Date of this Plan means upon approval by the City Council, effective for plan years starting January 1, 2018.

Election Form/Salary Reduction Agreement means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits, and Dependent Care FSA Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions. If an interactive voice-response system or web-based program is used for enrollment, the Election Form/Salary Reduction Agreement may be maintained on an electronic database in accordance with applicable laws.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in

Section 3.1.

Eligible Opt Out Arrangement means an Opt Out Arrangement that meets the conditions of Section 6.5.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or any individual classified by the Employer as an independent contractor for the period during which such individual is so classified (even if subsequently determined by the IRS, the Department of Labor, a court of competent jurisdiction, or the Employer to be a common-law employee of the Employer), whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer means City of Manhattan Beach.

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Health Flex Contribution means any Employer Contribution that meets the following requirements: (1) the Participant may not opt to receive the amount as a taxable benefit, (2)

the Participant may use the amount to pay for minimum essential coverage, and (3) the Participant may use the amount exclusively to pay for medical care, within the means of Code § 213.

Health FSA means health flexible spending arrangement.

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HMO means the health maintenance organization Benefit Package Option (if any) under the Medical Insurance Plan.

Medical Care Expenses has the meaning described in Section 7.3.

Medical Insurance Benefits means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

Medical Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing major medical-type benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Non-Health Flex Contribution means an Employer designated Contribution that does not meet the definition of a Health Flex Contribution.

Open Enrollment Period with respect to a Plan Year means the month of November in the year preceding the Plan Year, or such other period as may be prescribed by the Administrator.

Opt Out Arrangement means an arrangement where payment is made available to an Eligible Employee only if the Eligible Employee declines coverage, but may not be used to pay for Medical Insurance Benefits (whether or not the Eligible Employee receives the amount as a taxable benefit).

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Premium Payment Benefits, Health FSA Benefits, Dependent Care FSA Benefits, and Salary Reductions to pay for such Benefits; (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan with after-tax dollars outside of this Plan (if offered) and who have not elected any Health FSA Benefits, or Dependent Care FSA Benefits; and (c) those who decline to enroll in the Medical Insurance Plan and elect to receive a cash amount under an Opt-Out Arrangement or Eligible Opt-Out Arrangement.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

Plan means the City's Section 125 Flexible Benefits Plan as set forth herein and as amended from time to time.

Plan Administrator means the City of Manhattan Beach or third party that the City may designate. The contact person is the Human Resources Director for the City, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 11.1.

Plan Year means the calendar year (i.e., the 12-month period commencing January 1 and

ending on December 31).

PPO means the preferred provider organization Benefit Package Option (if any) under the Medical Insurance Plan.

Premium Payment Benefits means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

Premium Payment Component means the component of this Plan described in Article VI.

QMCSO means a qualified medical child support order, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in Section 8.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1); (b) a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, 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 year; or (c) a Participant's Spouse 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 year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the Dependent Care FSA Component, the term

Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a Qualifying Individual's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate. Subject to the eligibility requirements under a collective bargaining agreement, if any, an individual is eligible to participate in this Plan (including the Premium Payment Component, the Health FSA Component, and the Dependent Care FSA Component) if the individual: (a) is an Employee; (b) is eligible for the Medical Insurance Plan; and (c) has been employed by the Employer for 30 consecutive calendar days, counting his or her Employment Commencement Date as the first such day. Eligibility for Medical Insurance Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation. A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the termination of this Plan; or

(b) the date on which the Employee ceases (because of retirement, termination of

employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date(s) specified in the Medical Insurance Plan. Reimbursements from the Health FSA and Dependent Care FSA Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for Dependent Care FSA Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason other than for termination of employment, including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) ***Health Benefits****.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her

coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require Participants to continue all Medical Insurance Benefits and Health FSA Benefits coverage while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue such coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance Benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to

discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

In addition, the Plan may require Participants whose Medical Insurance Benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a per-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) ***Non-Health Benefits.*** If a Participant goes on a qualifying leave under the FMLA, then

entitlement to non-health benefits (such as Dependent Care FSA Benefits) is to be determined by the Employer's policy for providing such Benefits when Participants are on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant, or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 10.3(d) will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible. An Employee who first becomes eligible to participate in the Plan midyear may elect to commence participation in one or more Benefits on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 10.3. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan.

4.2 Elections During Open Enrollment Period. During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide a paper or electronic Election

Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Employee may elect to participate in the various Components of this Plan for the next Plan Year and authorize the necessary Salary Reductions to pay for the Benefits elected by completing the Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. However, for Premium Payment Component, the Employer may elect to offer automatic continuing enrollment in the option previously selected by the Employee in writing or as provided by a collective bargaining agreement.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement. If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the applicable time periods described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a midyear election change, as described under Section 10.3 or 10.4. If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a midyear election change as described under Section 10.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections. Unless an exception applies (as described in Article X), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII; and

(c) Dependent Care FSA Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

(a) ***Employer Contributions***. For Participants who elect Medical Insurance Benefits described in Article VI, the Employer may contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees, the Election Form/Salary Reduction Agreement, and/or any applicable collective bargaining agreement. The Employer may also designate Health Flex Contributions or Non-Health Flex Contribution that a Participant may allocate to the Medical Insurance Plan or Health FSA Benefit, as provided by any applicable collective bargaining agreement, Employer policy, or other contract related to this Plan. There are no Employer contributions for Health FSA Benefits or Dependent Care FSA Benefits.

(b) ***Participant Contributions***. Participants who elect Medical Insurance Benefits may pay for the cost of that coverage on a pre-tax Salary Reduction basis or with after-tax deductions by completing an Election Form/Salary Reduction Agreement, if permitted by the City. Participants who elect Health FSA Benefits or Dependent Care FSA Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) ***Salary Reductions per Pay Period****.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits, divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator. If a Participant increases his or her election under the Health FSA Component, or Dependent Care FSA Component to the extent permitted under Section 10.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 10.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator.

(b) ***Considered Employer Contributions for Certain Purposes****.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits, and the Dependent Care FSA Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) ***Salary Reduction Balance Upon Termination of Coverage****.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) ***After-Tax Contributions for Premium Payment Benefits****.* For those Participants who

elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

5.5 Forfeiture and Application of Unused Flexible Spending Accounts. After the period for filing claims specified in Article VII and Article VIII has expired for a Plan Year, and after all properly submitted claims for Medical Care Expenses and Dependent Care Expenses have been paid for such Plan Year, the Plan Administrator will determine the total credits remaining in Participants' Flexible Spending Accounts with respect to that Plan Year. Such credits will be forfeited by the Participants and will remain the property of the Employer; however, the Employer may use the forfeitures to pay reasonable administrative expenses. In addition, any Flexible Spending Account benefit payments that are unclaimed (e.g., uncashed benefit checks) as of the last day of the Plan Year following the Period of Coverage in which the underlying expense was incurred shall be forfeited and applied as described above.

ARTICLE VI. Premium Payment Component

6.1 Benefits. The Premium Payment Component offers benefits under the Medical Insurance Plan . Notwithstanding any other provision in this Plan, the Medical Insurance Benefit is subject to the terms and conditions of the Medical Insurance Plan, and no changes can be made with respect to such Benefit under this Plan (such as midyear changes in election) if such

changes are not permitted under the applicable Medical Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for the Medical Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) if permitted by the Employer, elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. A Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical Insurance Benefits that are provided to the Participant during the period that begins immediately following the close of that Plan Year and ends on the last day of that Plan Year).

6.2 Contributions for Cost of Coverage. The annual Employer Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, as described in an applicable collective bargaining agreement, memorandum of understanding, policy or other applicable document, which may or may not be the same amount charged by the insurance carrier. The Employer may also designate Health Flex Contributions that a Participant may allocate to the Medical Insurance Plan.

6.3 Benefits Provided Under the Medical Insurance Plan. The types and amounts of Medical Insurance Benefits, the requirements for participating in the Medical Insurance Plans, and the other terms and conditions of coverage, benefits, and claims of the Medical Insurance Plans are set forth in the Medical Insurance Plans, not this Plan.

6.4 Opt Out Arrangement. The Employer may establish an Opt Out Arrangement for Participants who decline to enroll in the Medical Insurance Plan. If an Opt Out Arrangement is established, the Participant may elect to take a cash amount established by the Employer in lieu of enrolling in the Medical Insurance Plan.

6.5 Eligible Opt Out Arrangement. An Employer may also establish an Eligible Opt Out Arrangement under this Plan as a condition to a Participant receiving a cash amount

established by the Employer in lieu of Medical Insurance Benefits. The conditions that must be satisfied for an Eligible Opt Out Arrangement are as follows:

(a) The Participant must provide proof of minimum essential coverage ("MEC") through another source (other than coverage in the individual market, whether or not obtained through Covered California);

(b) The proof of coverage must show that the Participant and all individuals in the Participant's expected tax family have (or will have) the required minimum essential coverage. A Participant's expected tax family includes all individuals for whom the Participant reasonably expects to claim a personal exemption deduction for the taxable year(s) that cover the Participant's plan year to which the opt-out arrangement applies;

(c) The Participant must provide reasonable evidence of the MEC for the applicable period. Reasonable evidence may include an attestation by the Participant;

(d) The Participant must provide the evidence/attestation every Plan Year;

(e) The Participant must provide the evidence/attestation no earlier than a reasonable time before coverage starts (e.g. open enrollment). The evidence/attestation may also be provided within a reasonable time after the Plan Year starts; and

(f) The opt-out payment cannot be made (and the Employer must not in fact make payment) if the Employer knows or has reason to know that the Participant or tax family member does not have the alternative coverage.

6.6 Medical Insurance Benefits; COBRA Contributions. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For individuals who cease to be eligible because of retirement, termination of employment, or layoff, Contributions for COBRA

coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless otherwise permitted by the Plan Administrator on a uniform and consistent basis). Contributions for COBRA coverage may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits. An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the Health FSA Component unless he or she is also eligible for the Medical Insurance Plan.

7.2 Contributions for Cost of Coverage of Health FSA Benefits. A Participant may direct Health Flex Contributions to Health FSA Benefits as provided by a collective bargaining agreement, Employer policy, or other contract related to this Plan, subject to the limitations in Section 5.2(a). The annual Contribution, including any Health Flex Contribution, for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

7.3 Eligible Medical Care Expenses for Health FSA. A Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which a Health FSA election is in force.

(a) ***Incurred***. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is billed or pays for the medical care.

(b) ***Medical Care Expenses***. Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §

213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

(1) premium payments;

(2) medicines or drugs, unless the medicine or drug is a prescribed drug or is insulin;

(3) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or

(4) any other expense excluded under Appendix A or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

7.4 Maximum and Minimum Benefits for Health FSA

(a) ***Reimbursement Availability; Uniform Coverage***. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account

pursuant to Section 7.5. Reimbursements will not be available for Medical Care Expenses incurred after participation in this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8.

(b) ***Maximum and Minimum Dollar Limits***. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $2,650 in 2018 (and as adjusted from time to time pursuant to Code § 125(i)), subject to Sections 7.4(c) and 7.5(c). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $120. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) ***Changes***. For Plan Years beginning after 2017, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code § 125(i).

(d) ***Effect on Maximum Benefits If Election Change Permitted***. Any change in an election under Article X (other than under Section 10.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account,

reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 10.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans. A Participant, who has a deficit balance under the Health FSA Account may not revoke or reduce his/her election under such account unless and until the deficit has been eliminated.

7.5 Establishment of Health FSA Account. The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Sections 5.5 and 7.6.

(a) ***Crediting of Accounts***. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) ***Debiting of Accounts***. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

(c) ***Available Amount Not Based on Credited Amount***. As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule.

(a) ***Use-or-Lose Rule****.* If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) ***Use of Forfeitures****.* All forfeitures under this Plan shall be used as provided by Section 5.5.

7.7 Reimbursement Claims Procedure for Health FSA.

(a) ***Timing****.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, prior to the expiration of the initial 15-day period. If the claim is incomplete, the Participant will have 45 days in which to complete the previously incomplete reimbursement claim.

(b) ***Claims Substantiation****.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the March 31 following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to

participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Participant's Health FSA Account for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section 7.9 and applicable IRS guidance regarding electronic payment card programs.

(c) ***Claims Denied****.* For reimbursement claims that are denied, see the appeals procedure in Article XI.

(d) ***Claims Ordering****.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA. When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in this Section 7.8, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component as the result of a COBRA qualifying event shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Individuals will only be eligible for COBRA continuation coverage if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such continuation coverage shall be subject to all conditions and limitations under COBRA, except that it shall not be terminated early for after-acquired group health coverage or Medicare entitlement.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals, Contributions for COBRA coverage for Health FSA Benefits shall be paid on an

after-tax basis unless permitted otherwise by the Plan Administrator on a uniform and consistent basis. Contributions for COBRA coverage may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

7.9 Electronic Payment Cards. If the Employer allows the Health FSA to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs.

ARTICLE VIII. Dependent Care FSA Component

8.1 Dependent Care FSA Benefits. An Eligible Employee can elect to participate in the Dependent Care FSA Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis.

8.2 Contributions for Cost of Coverage for Dependent Care FSA Benefits. The annual Contribution for a Participant's Dependent Care FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000 annual benefit amount is elected, then the annual Contribution amount is also $5,000.)

8.3 Eligible Dependent Care Expenses. Under the Dependent Care FSA Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) ***Incurred***. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) ***Dependent Care Expenses.*** "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services-provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's Dependent Care FSA imposes maximum benefit limitations), the Dependent Care FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) ***Qualifying Dependent Care Services.*** "Qualifying Dependent Care Services" means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the Dependent Care FSA Component and during the Period of Coverage; and (2) are performed-

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center, then the center must comply with all applicable state and local laws and regulations.

(d) ***Exclusion.*** Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;

- a Participant's child (as defined in Code § 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child as defined in Code § 152(c) (e.g., a former spouse who is the child's noncustodial parent).

8.4 Maximum and Minimum Benefits for Dependent Care FSA.

(a) ***Maximum Reimbursement Available***. The dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care FSA Account pursuant to Section 8.5, reduced by reimbursements during the Period of Coverage. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account.) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) ***Maximum and Minimum Dollar Limits***. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be the lowest of the following amounts:

- $5,000 if the Participant is married and files a joint return or single;
- $5,000 if the Participant is married and files a separate federal income tax return but only if the following conditions are met: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the Dependent Care FSA); (2) the Participant furnishes over half of the cost of maintaining such household during

the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household;

- $2,500 if the Participant is married and files a separate federal income tax return under circumstances other than those described above;
- the Participant's Earned Income for the calendar year; or
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse will be deemed to have earned income of at least $250 ($500 if the Participant has two or more Qualifying Individuals) for each month in which the Spouse is either (1) physically or mentally incapable of self-care (provided that the Spouse must have the same principal place of abode as the Participant for more than one-half of such year), or (2) a Student).

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $120.

(c) ***Changes.*** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement, applicable collective bargaining agreement, Employer policy, or other document relating to this Plan.

8.5 Dependent Care FSA Account. The Plan Administrator will establish and maintain a Dependent Care FSA Account with respect to each Participant who has elected to participate in the Dependent Care FSA Component as a recordkeeping account for the purpose of tracking contributions and forfeitures, but it will not create a separate fund or otherwise segregate assets for this purpose. A Participant's Dependent Care FSA Account will be credited during each Period of Coverage with an amount equal to the Participant's Salary Reduction Elections and debited for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage. The amount available for reimbursement of Dependent Care Expenses may not

exceed the year-to-date amount credited to the Participant's Dependent Care FSA Account, less any prior reimbursements for Dependent Care Expenses incurred during the Plan Year-i.e., it is based on the amount credited to the Dependent Care FSA Account at a particular point in time. Thus, a Participant's Dependent Care FSA Account may not have a negative balance.

8.6 Forfeiture of Dependent Care FSA Accounts; Use-It-or-Lose-It Rule. Any balance remaining in the Participant's Dependent Care FSA Account for a Period of Coverage after all reimbursements have been made for that Period of Coverage shall not be carried over to reimburse Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as provided by Section 5.5.

8.7 Reimbursement Claims Procedure for Dependent Care FSA.

(a) ***Timing***. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's approved Dependent Care Expenses or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension before the expiration of the initial 15-day period, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) ***Claims Substantiation***. A Participant who has elected to receive Dependent Care FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the March 31 following the close of the Plan Year in which the Dependent Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90

days after the date that eligibility ceases, as described in Section 8.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization, or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25.

(c) ***Debit Cards Used to Reimburse Dependent Care Expenses.*** At the beginning of the Plan Year or upon enrollment, the employee pays initial expenses to the dependent care provider and substantiates the initial expenses by submitting to Plan Administrator a statement from the dependent care provider substantiating the dates and amounts for the services

provided. After the Plan Administrator receives the substantiation (but not before the date the services are provided as indicated by the statement provided by the dependent care provider), the plan makes available through the debit card an amount equal to the lesser of: (A) the previously incurred and substantiated expense; or (B) the employee's total salary reduction amount to date. The card may be used to pay for subsequently incurred dependent care expenses. The amount available through the card may be increased in the amount of any additional dependent care expenses only after the additional expenses have been incurred.

(d) ***Claims Denied****.* For reimbursement claims that are denied, see the appeals procedure in Article XI.

8.8 Reimbursements from Dependent Care FSA After Termination of Participation. When a Participant ceases to be a Participant under Section 3.2, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, as long as the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

8.9 Report to Dependent Care FSA Participants. On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care FSA Component, as the Plan Administrator deems appropriate.

ARTICLE IX. HIPAA Provisions for Health FSA

9.1 General. As a HIPAA Health Plan, the Health FSA shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification

requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

9.2 Definitions. For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §160.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility

for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Health FSA or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 9.3. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Health FSA, even though the employee's duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health FSA functions.

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

9.3 Responsible Employees. Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health FSA. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA administration functions that the Employer performs on behalf of a Health FSA pursuant to Section 9.4.

Employees who perform the following functions on behalf of the Health FSA are Responsible Employees: (1) claims determination and processing functions; (2) Health FSA vendor relations functions; (3) benefits education and information functions; (4) Health FSA administration activities; (5) legal department activities; (6) Health FSA compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

9.5 Prohibited Uses and Disclosures. Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) ***Genetic Information***. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) ***Employment-Related Actions***. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) ***Other Benefits***. Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 9.4, shall not be a permitted use or disclosure.

9.6 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI

only to perform certain permitted and required functions on behalf of the Health FSA, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA's own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

(f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers' compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or

lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

9.7 Certification Requirement

The Health FSA shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health FSA any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 9.6, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in

accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI and Electronic PHI infeasible;

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA and the Employer's activities in its role as Health FSA sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the FSA.

9.8 Mitigation. In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action, up to and including termination.

9.9 Breach Notification. Following the discovery of any Breach of unsecured PHI, the Health FSA shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE X. Irrevocability of Elections; Exceptions

10.1 Irrevocability of Elections. A Participant's election under the Plan, including its Components, is irrevocable for the duration of the Period of Coverage to which it relates, except as provided in this Article X. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Package Options.

10.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) ***Timeframe for Making New Election***. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under

Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 10.3 (or within 60 days of the occurrence of an event described in Section 10.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) ***Effective Date of New Election****.* Elections made pursuant to this Section 10.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 10.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that any replacement coverage commences later).

(c) ***Effect of New Election Upon Amount of Benefits****.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and Dependent Care FSA Components, see Sections 7.4 and 8.4 respectively.

10.3 Events Permitting Exception to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan in accordance with the procedures described in Section 10.2.

(a) ***Open Enrollment Period (Applies to Premium Payment, Health FSA, and Dependent Care FSA Benefits)****.* A Participant may change an election during the Open Enrollment

Period in accordance with Section 3.2.

(b) ***Termination of Employment (Applies to Premium Payment, Health FSA, and Dependent Care FSA Benefits)***. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) ***Leaves of Absence (Applies to Premium Payment, Health FSA, and Dependent Care FSA Benefits)***. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) ***Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and Dependent Care FSA Benefits as Limited Below)***. A Participant may change his or her election under the Plan upon the occurrence of a Change in Status event only if the election is consistent with the event under both the applicable special consistency rules and the general consistency rule. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested election change meets the consistency requirements below.

> *General Consistency Rule*: A Participant's election change satisfies the general consistency requirement only if the election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer.
>
> *Special Consistency Rules*: Assuming that the general consistency rule is also satisfied, a requested election change must satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:
>
> 1. Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in

Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel Medical Insurance Benefits for the Spouse or Dependent, as applicable. However, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage.

2. Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under another employer's cafeteria plan or qualified benefit plan as a result of a change in marital or employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

3. Special Consistency Rule for Dependent Care FSA Benefits. With respect to the Dependent Care FSA Benefits, a Participant may change or terminate his or her election upon a Change in Status if the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

Special Rule for Health FSA Coverage: A Participant may not change his or her election to reduce Health FSA coverage during a Period of Coverage. However, a participant may cancel Health FSA coverage completely due to any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Any such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

(e) ***HIPAA Special Enrollment Rights (Applies Only to Premium Payment Benefits for the Medical Insurance Plan).*** 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 § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) 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: (A) the coverage was provided under COBRA, and the COBRA coverage was exhausted; or (B) 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;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or

placement for adoption;

(3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

(f) ***Certain Judgments, Decrees, and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to Dependent Care FSA Benefits)***. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child if the Order requires the Participant to provide coverage; or (2) change his or her election to revoke coverage for the child if the Order requires that another individual provide coverage under that individual's plan, and such coverage is actually provided.

(g) ***Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to Dependent Care FSA Benefits)***. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this

Plan becomes entitled to or enrolled in Medicare or Medicaid, then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the Medical Insurance Benefit of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage.

(h) ***Change in Cost (Applies to Premium Payment Benefits, to Dependent Care FSA Benefits as Limited Below, but Not to Health FSA Benefits)***. For purposes of this Section 10.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole

discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as a PPO) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are

otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) *Limitation on Change in Cost Provisions for Dependent Care FSA Benefits.* The above "Change in Cost" provisions (Sections 10.3(h)(1) through 10.3(h)(3)) apply to Dependent Care FSA Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) ***Change in Coverage (Applies to Premium Payment and Dependent Care FSA Benefits, but Not to Health FSA Benefits)****.*

The definition of "similar coverage" under Section 10.3(h) applies also to this Section 10.3(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her

employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 10.3(i)(1), a "Loss of Coverage" means a complete loss of coverage, including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation. In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option;
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(d) *Dependent Care FSA Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

10.4 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary

Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XI. Appeals Procedure

11.1 Procedure If Benefits Are Denied Under This Plan. If a claim for benefits under this Plan is wholly or partially denied, then the Employee or Participant may request review upon written application to the Committee. The appeal must be made in writing within 180 days after the Employee or Participant's receipt of the notice that the claim was denied. If the Employee or Participant does not appeal on time, the Employee or Participant will lose the right to appeal the denial and the right to file suit in court. Appeals under this Plan, including the Health FSA and Dependent Care FSA Components, will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives the request for review. The Committee may, in its discretion, hold a hearing on the denied claim.

11.2 Claims Procedures for Medical Dental, and Vision Insurance Benefits

Claims and reimbursement for Medical, Dental, and Vision Insurance Benefits shall be administered, respectively, in accordance with the individual claims procedures set forth in the

plan documents and/or summary plan descriptions for each plan respectively, if applicable.

11.3 Claims Deadline. Unless otherwise provided herein or required pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Employee or his or her designee to make sure this requirement is met.

11.4 Limitations Period for Filing Suit

Unless otherwise provided herein or required pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedure.

ARTICLE XII. Recordkeeping and Administration

12.1 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 11.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the direction,

information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

12.5 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Insurance Contracts. The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.7 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.

12.8 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an

Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XIII. General Provisions

13.1 Expenses. All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 5.5, Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to Dependent Care FSA Benefits, and then by the Employer.

13.2 No Contract of Employment. Nothing herein contained is intended to be construed as an employment contract or other arrangement between any Employee and the Employer and shall not be construed to imply that Employee will be employed for any specific period of time.

13.3 Amendment and Termination. This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan (including any Component) at any time for any reason by resolution of the Employer's governing body or by any person or persons authorized by the governing body to take such action.

13.4 Governing Law/Venue. This Plan shall be construed, administered, and enforced according to the laws of the State of California, to the extent not superseded by the Code or any other federal law. Any claim or action resulting from, relating to, or arising under The Plan shall only be brought in the Torrance Courthouse, Southwest Judicial District of Los Angeles,

California, and such Court shall have personal jurisdiction over any party named in the action.

13.5 Compliance With Code and Other Applicable Laws. It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

13.6 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.7 Indemnification of Employer. If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

13.8 Non-Assignability of Rights. The right of any Participant to receive reimbursement under this Plan shall not be assigned by the Participant and shall not be subject to claims by the Participant's creditors. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

13.9 Plan Provisions Controlling. In the event that the terms or provisions of any summary or description of this Plan conflict with the provisions of this Plan, the provisions of this Plan shall control.

13.10 Severability. If any part of this Plan is invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent permitted by law.

* * *

This document is executed this ____ day of _____. Year _____.

CITY OF MANHATTAN BEACH

By:_____

Its:_____

Appendix A

Exclusions

Medical Expenses That Are Not Reimbursable From the Health FSA

The City of Manhattan Beach Section 125 Flexible Benefits Plan document contains the general rules governing what expenses are reimbursable. This Appendix A, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA-that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under legal requirements applicable to health FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Medicines or drugs (other than insulin) available over-the-counter that have not been prescribed.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.

- Automobile insurance premiums.
- Transportation expenses of any kind, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code § 213(d).
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. § 1.125-5(k)(4) or other applicable law or regulations.