City of Temecula

Section 125
Cafeteria Plan Document

As Amended and Restated
January 1, 2026 for
Section 125 Cafeteria Plan

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CITY OF TEMECULA
SECTION 125 CAFETERIA PLAN

INTRODUCTION

The Plan Sponsor designated in the City of Temecula's Employer's Adoption Agreement (the City of Temecula hereinafter referred to as the "Employer") hereby establishes a Section 125 Cafeteria Plan (the "Plan") for its eligible Employees. Its purpose is to reward them by providing Benefits for those Employees who shall qualify hereunder and their qualifying Dependents and Spouses. The concept of this Plan is to allow employees to choose among different types of Benefits based on their own particular goals, desires, and needs and to reimburse the Eligible Employees of the Employer for allowable expenses incurred by them, their Spouses, and Dependents. The Plan shall be known as a "Section 125 Cafeteria Plan" (hereinafter referred to as the "Plan") and shall otherwise be referred to by the Plan Name provided within the Employer's completed Adoption Agreement, applicable collective bargaining agreements (MOU's) or compensation plans, resolutions, or contracts.

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

ARTICLE I
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

1.1 "Administrator" or **"Plan Administrator"** means the Plan Sponsor unless the Plan Sponsor has delegated any or all of its authority as the Administrator under this Plan to any third-party, pursuant to the terms of this Plan and in accordance with the terms of any applicable Service Agreement.

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

1.3 "Benefit" means any of the optional benefit choices selected by the Participant as outlined under Article IV below or as otherwise specified in the Employer's Adoption Agreement.

1.4 "Carryover Provision" means the carryover of any amount remaining unused in the Healthcare Flexible Spending Account as of the end of any Plan Year, pursuant to Section 6.3. For Plan Years prior to 2022, the maximum carryover amount is $500. For Plan Years beginning 2022, the maximum carryover amount may be changed by the Plan Administrator and shall be communicated to Employees through the election of Benefits form or another document, provided that the maximum carryover amount shall not exceed 20% of the maximum amount permitted under Code §125(i).

1.5 "Claims Extension Period" means the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year, pursuant to Section 7.8.

1.6 "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time, and which shall also include any governing Regulations or applicable guidance thereunder.

1.7 "Compensation" means the total cash remuneration received by the Participant from the Employer during a Plan Year prior to any reductions pursuant to a Salary Redirection Agreement authorized hereunder. Compensation shall include overtime, commissions, and bonuses.

1.8 "Dependent" means any individual who is defined under an Insurance Contract or who is a Qualifying Child or Qualifying Relative who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)), as applicable. A Dependent also includes an adult child of a Participant who as of the end of the calendar year has not attained age 26. A child for purposes of this Section 1.8 means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law, if applicable.

1.9 "Effective Date" means the Effective Date specified in the Employer's Adoption Agreement.

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

1.11 "Eligible Employee" means any Employee who has satisfied the eligibility requirements necessary to participate in the Plan as stated in the Employer's Adoption Agreement or as specified in the City of Temecula Schedule of Authorized Positions, the Memorandum of Understanding between the City of Temecula and Teamsters Local 986, the City of Temecula Management Compensation Plan, or the City of Temecula City Council Compensation Plan, as they may be amended, or other policies or contracts adopted by the Employer.

1.12 "Eligible Opt Out Arrangement" means an opt out arrangement that meets the conditions of Section 4.6.

1.13 "Employee" means any person who is employed by the Employer, but for all portions of the Plan, generally excludes any person who is employed as an independent contractor or any person who is considered self-employed under Code Section 401(c), as well as a greater than two percent (2%) shareholder in a Subchapter S corporation, as defined under Code Section 1372(b), a partner in a partnership or an owner or member of a limited liability company that elects partnership status on its tax return.

1.14 "Employer" means the Plan Sponsor and any Affiliated Employer which is listed on the Employer's Adoption Agreement; provided, however, that the Plan Sponsor retains authority as Plan Administrator for all purposes under the Plan and retains sole authority to amend or terminate the Plan in accordance with Article XIII.

1.15 "Employer Contribution" means the contributions as identified in the Employer's Adoption Agreement, or as specified in the Memorandum of Understanding between the City of Temecula and Teamsters Local 986, the City of Temecula Management Compensation Plan, or the City of Temecula City Council Compensation Plan, as they may be amended, or other policies or contracts adopted by the Employer, made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions may consist of Employer-provided Health Flex Contributions and non-Health Flex Contributions as specified in the Memorandum of Understanding between the City of Temecula and Teamsters Local 986, the City of Temecula Management Compensation Plan, or the City of Temecula City Council Compensation Plan, as they may be amended, or other policies or contracts adopted by the Employer. These contributions shall be allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V and the cost of eligible Benefits described under Article IV.

1.16 "Entry Date" means the earlier of the Plan Effective Date or the date an Employee becomes entitled to participate in the Plan as specified in the Employer's Adoption Agreement.

1.17 [Reserved.]

1.18 [Reserved.]

1.19 "**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 including dental and vision care, within the meaning of Code § 213, including group health coverage and Healthcare Flexible Spending Account benefits.

1.20 "Highly Compensated Employee" means, for the purposes of determining discrimination, an Employee described in Code Section 125 and the Treasury Regulations thereunder.

1.21 "Insurance Benefits" means the benefits provided under any applicable insurance program or policy included within the list of qualifying, nontaxable benefit programs that have been selected as part of the Employer's Adoption Agreement.

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

1.23 "Insurance Premium Payment Plan" means the plan of Insurance Benefits selected within the Employer's Adoption Agreement, which provides for the payment of Premium Expenses under this Plan.

1.24 "Insurer" means any insurance company that underwrites a Benefit under this Plan or, the Employer if the Benefit is self-funded and otherwise paid for out of the Employer's general assets or paid for through a separate trust established by the Employer.

1.25 "Key Employee" means an employee defined in Code Section 416(I)(1) and the Treasury Regulations thereunder.

1.26 "**Non-Health Flex Contribution"** means an Employer Contribution that does not meet the requirements of a "Health Flex Contribution".**1.27 "Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.28 "Plan" means this instrument, including all amendments and attachments thereto.

1.29 "Plan Year" means the 12-month period designated in the Employer's Adoption Agreement. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.30 "Premium Expenses" or **"Premiums"** means the Participant's cost for the Insurance Benefits described in the Employer's Adoption Agreement.

1.31 "Qualifying Child" means an individual who, unless otherwise described under Code Section 152(b):

- Is a child (as defined under Code Section 152(f)(1)) of the Employee, or a dependent of such child, or a brother, sister, stepbrother or stepsister of the Employee, or a descendent of any such relative;
- Who has the same principal residence, if allowed under local law, as the Employee for more than one-half of the current taxable year;
- Is under the age of 26 as of the end of the Plan Year in which the Employee was eligible under this Plan; and
- Has not provided over one-half of his or her own support during the current Plan Year.

1.32 "Qualifying Relative" means an individual who, unless otherwise described under Code Section 152(d) or (e):

- Is a child (as defined under Code Section 152(f)(1)), or descendant of a child, or a brother, sister, stepbrother, stepsister, father, mother or any of their ancestors, or any other relative as described under Code Section 152(d)(2), including an individual who has the same principal residence as the Employee and who is a member of the Employee's household;
- Has (with the exception of certain handicapped dependents described under Code Section 152(d)(4)) gross income for the Plan Year that is less than the allowable income exemption amount (as defined under Code Section 151(d) for that taxable year;
- For whom the Employee provides over one-half of the individual's support for that calendar year; and
- Is not an otherwise Qualifying Child of the Employee for any portion of the Plan Year.

1.33 "Regulations" means either temporary, proposed or final regulations, as applicable, issued or released by the U.S. Department of Treasury, and any further or related guidance or interpretations, as well as such other federal or state regulations as otherwise applicable herein.

1.34 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1.

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

1.36 "Special Limited COBRA Coverage" means COBRA coverage that allows a Participant who terminates employment for any reason other than death to elect to continue Healthcare Flexible Spending Account participation for the remainder of the Plan Year but not for the traditional 18-month period for COBRA.

1.37 "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 the principal place of abode of a child (within the meaning of Code Section 152(f)(1) with respect to whom such individual is entitled to a deduction for the taxable year) 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.

1.38 [Reserved].

1.39 [Reserved]

All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Employee of the Employer and its Affiliates who meets the eligibility requirements specified in the Employer's Adoption Agreement, the City of Temecula Schedule of Authorized Positions, the Memorandum of Understanding between the City of Temecula and Teamsters Local 986, the City of Temecula Management Compensation Plan, and/or the City of Temecula City Council Compensation Plan, as they may be amended, or any other Employer contract or policy or becomes an Eligible Employee and who executes a written election to participate shall be eligible to participate in the Plan on the date they have satisfied any applicable waiting period(s) specified in the Employer's Adoption Agreement (or the Effective Date of the Plan, if later) or any other eligibility criteria set forth herein. The eligibility and entry dates for the Healthcare Flexible Spending Accounts must not occur before eligibility for the employer-sponsored group health coverage.

2.2 EFFECTIVE DATE OF PARTICIPATION

Any Employee who is eligible under Section 2.1 may become a Participant effective as of the first day of the month coinciding with or next following date requirements are met. Any Employee who does not elect to participate in the Plan on the date the Employee first becomes eligible may later elect to participate during the Election Period and begin participating as of the first day of the corresponding Plan Year or an earlier Entry Date following a Change in Status pursuant to Section 5.4 hereof. Since this is a restated Plan, each Employee who was a Participant in the Plan on the day prior to the restated Effective Date and is an Employee of an Employer on the Effective Date shall remain a Participant.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of Benefits form, which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change their Benefit elections pursuant to Section 5.4 hereof.

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

2.4 TERMINATION OF PARTICIPATION

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

a) Termination of employment, subject to the provisions of Section 2.7;

b) The Participant ceases to be an Eligible Employee, which may be because of retirement, termination of employment, layoff, change of employment status, or reclassification.

c) The end of the Plan Year during which the individual became a limited Participant because of a change in employment status pursuant to Section 2.5, or any other reason;

d) Death, subject to the provisions of Section 2.8; or

e) The termination of this Plan, subject to the provisions of Section 13.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be an Eligible Employee because of a change in employment status or classification (other than through termination of employment), the Participant may become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs if permitted by the applicable memorandum of understanding or compensation plan, resolution, or contract. An employee will become a limited Participant if they meet the following three conditions:

a) The Participant has taken an unpaid leave of absence from the Employer or is no longer an Eligible Employee; and

b) The Participant elects under Section 3.1 to reduce their Salary Redirection to $0 as a result of the change in employment status or classification; and

c) Upon return to employment after a leave of absence or return becomes an Eligible Employee, the Participant re-elects under Section 5.1 to increase their Salary Redirection to the level that existed immediately before it was reduced to $0 (or to some other level if on account of and consistent with a change in status).

If COBRA applies, the Participant, while on the unpaid leave or in part-time employment status, will be given the opportunity to continue their Insurance Plans and Healthcare Flexible Spending Account following the terms of the applicable memorandum of understanding or

compensation plan, resolution, or contract. Premiums for the Participant's Insurance Benefits, as well as any applicable Premiums for the Participant's Healthcare Flexible Spending Account, may continue to be paid on a pre-tax basis provided the Participant receives Compensation during the leave period. If, however, the Participant receives no Compensation during the leave period, the Participant may continue Benefits under the Plan through payment of all Premiums with after-tax dollars outside of the Plan. Regardless of how Premiums are paid (either pre-tax or after-tax), the Participant will remain a full Participant in the Plan provided all Premiums are paid within 30 days of any due date.

As a limited Participant, except as otherwise provided herein, no further Salary Redirection may be made on behalf of the Participant and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant's Dependent Care Assistance Account may be used during such Plan Year to reimburse the limited Participant for any allowable employment-related dependent expenses incurred during the Plan Year, subject to any other terms and conditions that are applicable under Article VII herein.

Further, in accordance with Article VI, any balances in the limited Participant's Healthcare Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable medical expenses incurred during the portion of the Plan Year in which the Employee was a full Participant in the Plan.

Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided they otherwise satisfy the participation requirements set forth in this Article II as if they were a new Employee and made an election in accordance with Section 5.1.

2.6 FAMILY AND MEDICAL LEAVE ACT OF 1993

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's Benefits under this Plan on the same terms and conditions as though they were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue their coverage). If the Employee opts to continue their coverage, the Employee may pay their share of the Premium through one of the following methods:

a) **Prepayment**. Under the prepayment option, the Participant increases their Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.

b) **Pay-as-you go**. With the pay-as-you-go option, the Participant shall continue to pay Premiums on a regular basis throughout the FMLA leave. If the Participant continues to receive a salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if they had not taken the leave. On the other hand, if the Participant's FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but the Participant is

required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.

c) **Catch Up**. The Administrator provides the funding for necessary coverage during the leave and subsequently withholds “catch-up” amounts from the Employee’s pay upon their return.

Upon return from such leave, that has been or is being paid for under one of the methods referred to above, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

However, for the Healthcare Flexible Spending Account, if the coverage terminates due to revocation of the Benefit due to nonpayment of contributions by the Participant, three options will be offered upon the Participant’s return to work:

d) **Proration.** The actual amounts contributed by the Participant would remain in effect for the duration of the Plan Year and the maximum contribution amount would be reduced proportionately for the time that the Participant was not paying contributions.

e) **Reinstatement.** The Participant may elect to reinstate the level of coverage in effect when the leave began, with applicable contribution amounts being made up for the remainder of the Plan Year.

f) **In Accordance with an Applicable Policy, MOU, Compensation Plan, Resolution, or Contract.** The Participant may elect to reinstate the level of coverage and make applicable contribution amounts for the remainder of the Plan Year if permitted and in accordance with an applicable Employer policy, memorandum of understanding, compensation plan, resolution, or contract.

Furthermore, if a Participant goes on a qualifying paid leave under the FMLA, to the extent required by the FMLA, the Employee will continue coverage while on FMLA by the method normally used during any paid leave.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

2.7 TERMINATION OF EMPLOYMENT

If a Participant terminates employment with the Employer for any reason other than death, their participation in the Plan shall be governed in accordance with the following:

a) With regard to Benefits that are insured, the Participant’s participation in the Plan shall cease, subject to the Participant’s right to continue coverage if COBRA applies or under any Insurance Contract for which Premiums have already been paid.

b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related dependent care expense reimbursements for the remainder of the Plan Year in which termination occurs, provided the claims are submitted within the grace period or Claims Extension Period as defined in Section 7.8. Reimbursement for such claims will be based on the level of the Participant's Dependent Care Assistance Account as of the date of termination.

c) With regard to the Healthcare Flexible Spending Account, the Participant may be able to elect to continue participation in the Plan in accordance with final and proposed IRS Regulations and as further provided below:

1) COBRA continuation coverage will not be offered to Healthcare Flexible Spending Account Participants under the following circumstance:

(a) The Healthcare Flexible Spending Account has a deficit (i.e., it is overspent) at the time of the Qualifying Event (i.e., if, taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year)

2) The Participant will qualify for Special Limited COBRA Coverage and can elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which the Qualifying Event occurs if:

(a) The Healthcare Flexible Spending Account is exempt from HIPAA's portability rules The Healthcare Flexible Spending Account is exempt from HIPAA's portability rules if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the Salary Redirection or, if greater, the Salary Redirection plus $500; and

(b) For the Plan Year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum Benefit available to the Qualified Beneficiary for the Plan Year.

3) If the Healthcare Flexible Spending Account qualifies for Special Limited COBRA Coverage and the Participant elects to continue participation as set forth under subparagraph (2)(b) above, the Participant's ability to continue coverage under the Healthcare Flexible Spending Account shall cease as of the end of the Plan Year in which the Qualifying Event occurs. Any such fees shall be the responsibility of the Participant or Qualified Beneficiary;

4) If the Healthcare Flexible Spending Account is not exempt from HIPAA's portability rules, the Participant shall have the ability to continue coverage under the Healthcare Flexible Spending Account under procedures and conditions set forth below.

For purposes of these rules, "Qualifying Event" means the occurrence of any of the following:

a) Death of a Covered Employee;

b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;

c) Divorce or legal separation of a Covered Employee from the Employee's Spouse;

d) A Covered Employee's becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act; or

e) A Dependent child of a Covered Employee ceasing to be a Dependent.

A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event, (i) an Employee of the Employer (including persons who are considered to be "employees" within Code Section 401(c), directors, and independent contractors) covered under a health plan offered under the Plan as of such day (such persons are typically referred to as "Covered Employees"); (ii) the Spouse of the Covered Employee; or (iii) a Dependent of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (other than for gross misconduct) or a reduction of hours of the Covered Employee's employment. A child born or placed for adoption with the Covered Employee during continuation coverage will also be considered as a Qualifying Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will also be treated as a Qualified Beneficiary for purposes of these rules.

The Plan Administrator will notify Healthcare Flexible Spending Account Participants as to their COBRA eligibility (if any). The Plan Administrator shall also notify Healthcare Flexible Spending Account Participants as to their HIPAA rights and responsibilities under Code Section 9801 (including applicable provisions pertaining to HIPAA certification, portability, creditable coverage, and special enrollment procedures) if the Plan is not exempt from HIPAA's portability rules under Section 2.7(c)(2) above.

If the Participant elects to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant may continue to seek reimbursement from the Healthcare Flexible Spending Account. The Participant shall be required to make contributions to the account based on the elections made prior to the beginning of the Plan Year.

If the Participant does not elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be

made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding their date of termination, provided the claims are submitted within the grace period. In the event a Participant terminates participation in the Healthcare Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or Benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

2.8 DEATH OF A PARTICIPANT

If a Participant dies during any Plan Year and at the time of death they have not received the total reimbursements available for the Plan Year, the Participant's surviving Spouse, children, or legal representatives can continue to submit claims for expenses incurred during the Plan Year pursuant to COBRA provisions stated in Section 2.7.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

If a Participant's Employer Contribution to this Plan is not sufficient to cover the cost of Benefits or Premium Expenses being provided and elected pursuant to Articles IV and V, the Participant's Compensation will be reduced in an amount equal to the difference between the cost of Benefits they elected and the amount of Employer Contribution available to the Participant. Such reduction in Compensation shall be their Salary Redirection, which the Employer will use on behalf of the Participant, together with their Employer Contribution, to pay for the Benefits elected by the Participant. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first pay date of the month following the Employee's Entry Date up to and including the last day of the Plan Year. These Salary Redirection contributions shall be allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

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

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants.

Any contributions made or withheld from an Employee's Compensation, pursuant to the Employee's signed Salary Redirection Agreement for the Healthcare Flexible Spending Account or Dependent Care Assistance Program shall be credited to such account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Healthcare Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 3.1.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Upon becoming a Participant prior to each Plan Year, a Participant must allocate their Employer Contributions and Salary Redirection amounts, if any, among the Plan of Benefit Options indicated in the Employer's Adoption Agreement.

4.2 HEALTHCARE FLEXIBLE SPENDING ACCOUNT BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Healthcare Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 RESERVED

4.5 INSURANCE BENEFIT

Each Participant may elect to be covered under the Employer's Insurance Contract(s) selected in the Employer's Adoption Agreement for the Participant, their Spouse, and their Dependents, as applicable and pursuant to the memorandum of understanding, resolution, or contract. The Employer may select suitable Insurance Contracts for use in providing their health insurance benefit. The rights and conditions with respect to the benefits payable from such Insurance Contract shall be determined therein, and such Insurance Contract shall be incorporated herein by reference.

4.6 CASH BENEFIT

The Employer has established an Eligible Opt Out Arrangement as a condition to an Eligible Employee receiving any Employer Contribution that is a non-Health Flex Contribution as taxable income (i.e., cash) in lieu of enrolling in City-sponsored health insurance. Employees cannot receive taxable income for Employer Contributions that are Health Flex Contributions.

The conditions that must be satisfied for the Eligible Opt Out Arrangement are as follows and subject to any applicable Employer policy, memorandum of understanding, resolution, contract, or Employer compensation plan or other limitations, as determined by the Employer's Adoption Agreement, Employer policy, memorandum of understanding, resolution, contract, or Employer compensation plan:

a) The Eligible Employee must have minimum essential health coverage through another source (other than coverage in the individual market, whether or not obtained through Covered California);

b) All individuals in the Eligible Employee's expected tax family must have (or will have) the required minimum essential health coverage. An Eligible Employee's expected tax family includes all individuals for whom the Eligible Employee reasonably expects to claim a personal exemption deduction for the taxable year(s) that cover the Eligible Employee's Plan Year to which the opt-out arrangement applies;

c) The Eligible Employee must provide reasonable documentation of minimum essential health coverage pursuant to the Affordable Care Act ("ACA"), which must cover both the Eligible Employee and all individuals in the Eligible Employee's expected tax family, if any, for the applicable period. Reasonable evidence may include an attestation by the Eligible Employee;

d) Each year, during the Elections Period or as otherwise required by the Employer, the Eligible Employee must provide the Employer with an attestation or other reasonable documentation, subject to the Employer's approval confirming such alternate coverage.

e) The Eligible Employee must provide the attestation or reasonable documentation no earlier than a reasonable time before coverage starts (e.g. Elections Period). The attestation or reasonable documentation may also be provided within a reasonable time after the Plan Year starts; and

f) According to the ACA, the Employer cannot make payment if the Employer knows or has reason to know that the Eligible Employee or a member of the Eligible Employee's expected family does not have the alternative minimum essential health coverage.

4.7 NONDISCRIMINATION REQUIREMENTS

a) It is the intent of this Plan to provide Benefits to a classification of employees that the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125, if applicable to such Eligible Employees or Participants.

b) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or nontaxable Benefits, it shall be done in the following manner. First, the nontaxable Benefits of the affected Participant (either an Employee who is Highly Compensated or a Key Employee, whichever is applicable) who has elected the highest amount of nontaxable Benefits for the Plan Year shall have their nontaxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of their nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the second highest amount of nontaxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among non-Insurance Benefits, and once all non-Insurance Benefits are expended, proportionately among delineated Benefits. Insurance contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided they elect to do so before their Effective Date of participation pursuant to Section 2.2, or for a newly eligible Employee, no more than 60 days after their date of hire. For any such newly eligible Employee, if coverage is effective as of the date of hire pursuant to Section 2.1 above, such Employee shall be eligible to participate retroactively as of their date of hire. Newly eligible Employee Election amounts will be collected on the first pay date of the month after their election was received. However, if such Employee does not complete an application to participate and Benefit election form and deliver it to the Administrator before such date, their Election Period shall extend 60 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 60-day election period pursuant to this Section 5.1 shall not be effective until the first pay date concurrent with or following the later of such Participant's Effective Date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

5.2 SUBSEQUENT ANNUAL ELECTIONS

With the exception of an Insurance Benefit premium election that is made as of the initial enrollment in the Plan, each Participant shall be given the opportunity to annually elect, on an election of Benefits form to be provided by the Administrator, which Benefit options they wish to select Any such election shall be effective during the Plan Year, which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

b) A Participant may terminate participation in the Plan by notifying the Administrator in writing during the Election Period that they do not want to participate in the Plan for the next Plan Year;

c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, or until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of Benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the

Plan for the upcoming Plan Year for the Healthcare Flexible Spending Account and/or Dependent Care Assistance Program. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year, until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change. Elections under the Insurance Benefit shall remain in effect for such subsequent Plan Year.

5.4 CHANGE OF ELECTIONS

a) With the exception of any specific circumstances otherwise described below, any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, 1) a change in status occurs, and 2) the requested revocation and new election satisfy the consistency requirements in Section 5.5. Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than first day of the month coinciding with or next after the election of Benefits form is completed and returned to the Administrator. For this purpose, a change in status includes the following events:

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

2) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

3) **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or returns from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this subsection. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status;

4) **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements.** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance;

5) **Residency.** A change in the place of residence of the Participant, Spouse, or Dependent;

6) **Special requirements.** concerning the Family and Medical Leave Act (FMLA) and the Health Insurance Portability and Accountability Act (HIPAA); and

7) **Other.** Such other events that the Administrator (in its sole discretion) determines to be consistent with and attributable to a change in status. Additional proof may be required by the Administrator to support any change of status election submitted by a Participant.

b) The Participant may change an election for accident coverage, if any, or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).

c) If the change in status is due to a change in the Participant's marital status, under item 1) above, or a change in employment status of the Participant's Spouse or covered Dependents under item 3) above, the Participant may elect to increase or decrease group-term life coverage and/or group disability coverage, if any, corresponding with that change in status.

d) In the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:

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

2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child and such coverage is actually provided.

e) A Participant may change elections to cancel accident coverage, if any, or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident coverage, if any, or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Further, if the Participant or the Participant's Spouse or Dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident coverage, if any, or health coverage of the individual who loses Medicare or Medicaid eligibility.

f) A Participant may make a prospective election change to add group health coverage for the Participant or the Participant's Spouse or Dependent if such individual(s) lose coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a medical care program of an Indian Tribal government (as defined in Code Section 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).

In addition, to the extent permitted under the Children's Health Insurance Program Reauthorization Act of 2009, an Eligible Employee may enroll and a Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), in the event that either (i) the Employee or his Dependent is covered under a plan offered under Medicaid or a State Children's Health Insurance Program (SCHIP) established under Title XXI of the Social Security Act and such coverage is terminated as the result of a loss of eligibility, or (ii) the Employee or Dependent becomes eligible for a state premium assistance subsidy from a plan offered under Medicaid or through a SCHIP). In either case, the Employee must meet the 60 day notice requirements imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

g) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage; or drop coverage prospectively if there is no other benefit package option available that provides similar coverage. This Plan treats coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.

h) If the cost of a Benefit provided under the Plan decreases significantly during a Plan Year, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; and employees who are otherwise eligible under the Plan may elect the benefit package option, subject to the terms and limitations of the benefit package option.

i) If the coverage under a Benefit is significantly curtailed and such curtailment results in a loss of coverage, or ceases during a Plan Year, any affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar

coverage or drop coverage prospectively if there is no other benefit package option available that provides similar coverage.

j) If the coverage under a Benefit is significantly curtailed and such curtailment does not result in a loss of coverage, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar coverage.

k) If, during the period of coverage, a new benefit package option or other coverage option is added (or an existing benefit package option or other coverage option is eliminated), or a significantly improved existing benefit package option is added, then the affected Participants and employees who are otherwise eligible under the Plan may elect the newly added or significantly improved option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

l) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's, or Dependent's employer if 1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its Participants to make a change; or 2) the cafeteria plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's, or Dependent's employer.

m) 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 different dependent care provider becomes available to take care of the child at no charge, then the Participant may cancel coverage. A cost change is also allowable in the Dependent Care Assistance Program if the cost change is imposed by the dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8). However, a Participant shall not be permitted to change an election to the Healthcare Flexible Spending Account as a result of a cost or coverage change under this subsection.

n) Generally, the termination of employment by a Participant shall not be considered a change in status. Therefore, upon termination, such Participant shall not be entitled to change existing Benefit elections. Rather, such termination shall constitute a revocation of all existing Benefit elections, except with regard to the Healthcare Flexible Spending Account, in which case the Participant’s election shall be governed by Section 2.7.

o) Notwithstanding any other provision of this Plan, the Administrator may 1) permit a Participant to revoke (and subsequently reinstate) their election of one or more

Benefit coverages under the Plan and 2) adjust a Participant's Compensation redirection as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any Regulations pertaining thereto.

5.5 CONSISTENCY REQUIREMENT

a) A Participant's requested revocation and new election will be consistent with a change in status 1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Plan of the Employer or under a Plan maintained by the employer of the Participant's Spouse or Dependent, and 2) with respect to dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses defined in Code Section 21(b)(2)). A change in status election is not consistent if the change in status is due to the Participant's divorce, annulment, or legal separation from a Spouse; the death of a Spouse or Dependent; or a Dependent ceases to satisfy the eligibility requirements for coverage, yet the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. Likewise, if the Participant, Spouse, or Dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

b) Regardless of the consistency requirement, if the individual, the individual’s Spouse, or Dependent becomes eligible for continuation coverage under the Employer’s group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage.

ARTICLE VI
HEALTHCARE FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

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

6.2 DEFINITIONS

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

a) **"Healthcare Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Health Flex Contribution, non-Health Flex Contribution, or Salary Redirection may be allocated and from which all allowable medical expenses may be reimbursed. The City also offers a Limited-Purpose Healthcare Flexible Spending Account that reimburses only vision care, dental care, and preventative care expenses (as defined in Code Section 223(c)). Participants can either enroll in the Healthcare Flexible Spending Account or the Limited-Purpose Healthcare Flexible Spending Account but not enroll in both and must choose their option for the entire Plan Year.

b) **"Healthcare Flexible Spending Account Plan"** means the Plan of Benefits contained in this Article, which provides for the reimbursement of eligible medical expenses incurred by a Participant, their Spouse, or their Dependents. The City also offers a Limited-Purpose Healthcare Flexible Spending Account Plan that reimburses only vision and dental expenses.

c) **"Highly Compensated Employee"** means for the purpose of this Article and determining discrimination under Code Section 105(h) a Participant who is:

   1) One of the five highest paid officers;

   2) A shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

   3) Among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

d) **"Incurred"** means a medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the medical care.

e) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the Participant as a deduction in determining their tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as Premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or their Spouse or Dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined under Code Section 7702B.

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

6.3 FORFEITURES AND CARRYOVER

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

Notwithstanding this provision, the provisions of the Plan concerning the payment of qualifying expenses, which include payment from any Healthcare Flexible Spending Account that would otherwise be forfeited if not incurred by the end of the Plan Year, are as follows:

For Plan Years prior to 2022, the Plan shall provide for a carryover of $500 of any amount remaining unused in a Healthcare Flexible Spending Account as of the end of the Plan Year, except as otherwise provided in Article XVI. For Plan Years beginning after 2022, the maximum carryover amount may be changed by the Plan Administrator and shall be communicated to Employees through the election of Benefits form or another document, provided that the maximum carryover amount shall not exceed 20% of the maximum amount permitted under Code §125(i). Such carryover amount shall be used to pay or reimburse Medical Expenses under any Healthcare Flexible Spending Account incurred during the entire Plan Year to which it is carried over.

Such carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the limitation on allocations for the following Plan Year, as described in Section 6.4.

A Participant who is otherwise eligible for the Healthcare Flexible Spending Account for a Plan Year but does not make a Healthcare Flexible Spending Account election for that Plan Year may use any carryovers from the preceding Plan Year for Medical Expenses incurred in the current or preceding Plan Year. However, an Employee or other individual must be a Participant in the Healthcare Flexible Spending Account as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made.

Medical Expenses incurred during a Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses, cannot exceed the maximum carryover amount, and will count against the maximum carryover amount.

If unused Healthcare Flexible Spending Amounts remain for a Plan Year after all reimbursements have been made for that Plan Year in excess of the amount that can be carried over, the Participant will forfeit all rights with respect to those amounts, which will be subject to the Plan's provisions regarding forfeitures.

6.4 LIMITATION ON ALLOCATIONS

a) Notwithstanding any provision contained in this Healthcare Flexible Spending Account to the contrary, the maximum amount, which may be allocated by a Participant in or on account of any Plan Year to this Account, is prescribed in the Employer's Adoption Agreement. The minimum amount which may be allocated by a Participant in or on account of any Plan Year to this Account shall be $0.00.

b) **Cost of Living Adjustment.** In no event shall the amount of salary redirections on the Healthcare Flexible Spending Account exceed $3,400 in taxable year 2026 and as adjusted and indexed for other taxable years in accordance with Code Section 125(i)(2).

c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), or (m), relating to controlled groups and affiliated service groups, are treated a single employer for purposes of the $3,400 limit, as adjusted and indexed for other taxable years in accordance with Code Section 125(i)(2).

d) **Carryover Provision.** The carryover amount will not count against or otherwise affect the $3,400 limit (as adjusted and indexed for other taxable years in accordable with Code Section 125(i)(2)) on annual Healthcare Flexible Spending Accounting Salary Redirections.

6.5 NONDISCRIMINATION REQUIREMENTS

a) To the extent legally applicable, it is the intent of this Healthcare Flexible Spending Account not to discriminate in violation of the Code and the Treasury Regulations thereunder.

b) If the Administrator deems it necessary to avoid discrimination under this Healthcare Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Healthcare Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 that elected to contribute the highest amount of the account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the account equals the amount designated for the account by the next member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 who has elected the second highest contribution to the Healthcare Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative

act under this paragraph, shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH SECTION 125 CAFETERIA PLAN

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

6.7 HEALTHCARE FLEXIBLE SPENDING ACCOUNT CLAIMS

a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8, even though the submission of such a claim occurs after their participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year.

b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Healthcare Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Health Flex Contributions, Non-Health Flex Contributions, or Salary Redirection amounts which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any healthcare plan covering the Participant and/or the Participant's Spouse or Dependents.

c) Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid within 30 days after receipt by the Administrator; provided however, that if a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year or the 90-day period immediately following a Participant's date of termination, those Medical Expense claims shall not be considered for reimbursement by the Administrator. The 30-day time period for the Administrator to pay claims for reimbursement of Medical Expenses may be extended by an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

d) Claims Substantiation. A Participant who has elected to receive Healthcare Flexible Spending Account Benefits may apply for reimbursement by submitting a request in writing to the Administrator in such form as the Administrator may prescribe, by no later than 90-days following the close of the Plan Year in which the Medical 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 setting forth:

1) The person(s) on whose behalf Medical Expenses have been incurred;

2) The nature and date of the Medical Expenses so incurred;

3) The amount of the requested reimbursement;

4) A statement that such Medical Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

5) Other such details about the expenses that may be requested by the Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or 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 Medical Expenses have been incurred and showing the amounts of such Medical Expenses, along with any additional documentation that the Plan Administrator may request. If the Healthcare Flexible Spending Account 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 Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

Unless payment arrangements are as directed within this paragraph or as otherwise specified below, reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may also be made directly to the service provider. The Administrator shall retain a file of all such statements and applications.

e) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article VIII.

ARTICLE VII
DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of employment-related dependent care expenses. All amounts reimbursed under this

Dependent Care Assistance Program shall be periodically paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

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

a) **"Dependent Care Assistance Account"** means the account established for a Participant pursuant to this Plan to which part of their Salary Redirection and/or non-Health Flex Contribution may be allocated and from which all employment-related dependent care expenses of the Participant may be reimbursed.

b) **"Dependent Care Assistance Program"** means the program of Benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

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

d) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services, which if paid by the Participant, would be considered employment-related expenses under Code Section 21(b)(2).

Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there is one or more Qualifying Dependents with respect to such Participant. The determination of whether an amount qualifies as an employment-related dependent care expense shall be made subject to the following rules:

1) If such amounts are paid for expenses incurred outside of the Participant's household, they shall constitute employment-related dependent care expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(f)(1) (or deemed to be, pursuant to Section 7.2(f)(3)), or for a Qualifying Dependent as defined in Section 7.2(f)(2) (or deemed to be, pursuant to Section 7.2(f)(3)) who regularly spends at least 8 hours per day in the Participant's household;

2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable State and local laws and regulations, including licensing requirements, if any; and

3) Employment-related dependent care expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.

e) **"Highly Compensated Employee"** means an Employee who is a Highly Compensated Employee within the meaning of Code Section 414(q) and the Treasury Regulations thereunder.

f) **"Qualifying Dependent"** means, for Dependent Care Assistance Program purposes,

1) A Dependent (as defined under Code Section 152(a)(1) who is under the age of 13;

2) A Qualifying Child, a Qualifying Relative or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one-half of year; or

3) A Dependent that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

g) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply their Salary Redirection and/or non-Health Flex Contribution to Dependent Care Assistance Program Benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Salary Redirection and/or Non-Health Flex Contributions that they have elected to apply toward their Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any employer-related dependent care expense reimbursements incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs employment-related dependent care expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which they are a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31 of each calendar year, the Employer shall furnish to each Employee who was a Participant and received Benefits under Section 7.6 during the prior calendar year, a statement of all such Benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES AND CLAIMS EXTENSION PERIOD

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

Notwithstanding this provision, the provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include but is not limited to payment from dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year are amended in the following respects:

a) Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.

b) Claims Extension Period—Defined. For purposes of these rules, the "Claims Extension Period" shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year.

c) Order of Expense or Benefit Payment. Amounts remaining in the Participant's applicable dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan

account (e.g., excess amounts within a participant's dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).

d) Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing all allowable claims submitted during the Claims Extension Period, pursuant to b) above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.

e) Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or ($7,500 ($3,750 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)) or such lesser or greater amount as determined by the Department of Treasury or the IRS for future taxable years. The minimum amount that a Participant may elect to receive under this Plan in the form of reimbursements for dependent care expenses shall be $0.00.

7.10 NONDISCRIMINATION REQUIREMENTS

a) To the extent legally applicable, it is the intent of this Dependent Care Assistance Program that contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d).

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

c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees defined under Section 7.2(e) or to principal shareholders or owners as set forth in this Section, it may, but shall not be required to, reject any elections or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the

Highly Compensated Employee that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph, shall be forfeited.

7.11 COORDINATION WITH SECTION 125 CAFETERIA PLAN

Participants under the Plan are eligible to receive Benefits under this Dependent Care Assistance Program as specified in the Memorandum of Understanding between the City of Temecula and Teamsters Local 986, the City of Temecula Management Compensation Plan, or the City of Temecula City Council Compensation Plan, as they may be amended, or other policies or contracts adopted by the Employer. The enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

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

a) The Dependent or Dependents for whom the services were performed;

b) The nature of the services performed for the Participant, the cost of which they wish reimbursement;

c) The relationship, if any, of the person performing the services to the Participant;

d) If the services are being performed by a child of the Participant, the age of the child;

e) A statement as to where the services were performed;

f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

g) If the services were being performed in a daycare center, a statement

1) That the daycare center complies with all applicable laws and regulations of the state of residence,

2) That the daycare center provides care for more than six individuals (other than individuals residing at the center), and

3) Of the amount of fee paid to the provider.

h) If the Participant is married, a statement containing the following:

1) The Spouse's salary or wages if they are employed, or

2) If the Participant's Spouse is not employed, that

(a) They are incapacitated, or

(b) They are a full-time student attending an educational institution and the months during the year which they attended such institution.

i) If a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year, the Administrator shall not consider those claims for reimbursement.

j) Subject to Section 7.13, all Dependent Care Assistance claims incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8 of the Plan, even though the submission of such a claim occurs after their participation hereunder ceases, provided that the Dependent Care Assistance Expenses were incurred during the applicable Plan Year prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled) and provided that 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.

k) The Administrator shall direct the reimbursement to each eligible Participant for all allowable employment-related dependent care expenses, up to a maximum of the amount designated by the Participant for the Dependent Care Assistance Program for the Plan Year. Reimbursements shall be made available to the Participant throughout the year up to the level of Salary Redirection and/or non-Health Flex Contributions which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any Dependent Care Assistance Plan covering the Participant and/or the Participant's Spouse or Dependents.

l) Notwithstanding anything in this Section to the contrary, Dependent Care Expenses incurred during the Claims Extension Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Claims Extension Period relates, if selected in the Employer's Adoption Agreement.

Furthermore, the Participant shall provide a written statement that the Dependent Care Assistance Expense has not been reimbursed or is not reimbursable under any other Dependent Care Assistance Plan coverage and, if reimbursed from the Dependent Care Assistance Program, such amount will not be claimed as a tax credit. The Administrator shall retain a file of all such applications.

Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's dependent care expenses (if the Administrator approves the claim), or the 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 Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

For reimbursement claims that are denied, see the appeals procedure in Article VIII.

7.13 REIMBURSEMENTS FROM DEPENDENT CARE ASSISTANCE PROGRAM AFTER TERMINATION OF PARTICIPATION

When a Participant ceases to be a Participant of the Dependent Care Assistance Program, the Participant's Salary Redirections and election to participate will terminate. Except as otherwise provided in this Article (regarding certain individuals who may be reimbursed from prior Plan Year amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for dependent 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 dependent care expenses incurred during the Plan Year prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled), provided that 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.

ARTICLE VIII
APPEALS PROCEDURE

8.1 PROCEDURE IF BENEFITS ARE DENIED UNDER THIS PLAN

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan.

ARTICLE IX
RESERVED

ARTICLE X
RESERVED

ARTICLE XI
RESERVED

ARTICLE XII
ADMINISTRATION

12.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full authority and discretion to administer the Plan in all of its details or may delegate a portion of such authority to any third party, subject, however, to applicable requirements of law. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

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

b) To interpret the Plan, with the Administrator's interpretations thereof to be final and conclusive on all persons claiming Benefits under the Plan;

c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive Benefits provided under the Plan;

d) To the extent applicable and considering this is a non-federal government plan covering collectively bargained employees, to reject elections or to limit contributions or Benefits for certain Highly Compensated Participants or other affected Participants if the Administrator deems such to be necessary in order to avoid discrimination under the Plan in violation of applicable provisions of the Code, or maintain compliance with any other applicable provisions of the Plan or other requirements of the law;

e) To provide Employees with a reasonable notification of their Benefits available under the Plan;

f) To approve reimbursement requests and to authorize the payment of Benefits; and

g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan; and

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

Any determination by the Administrator shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any plan of Insurance Benefits selected by the Employer under Paragraph 8 of its signed Adoption Agreement shall not be subject to review under this Plan, and the Administrator's authority

under this Section 12.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan or policy. Any procedure, discretionary act, interpretation, or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury Regulations thereunder.

12.2 METHOD OF BENEFIT PAYMENT

a) The Administrator shall make, or otherwise direct any Trustee to make (if applicable) any and all payments or other reimbursements in the manner specified herein and as otherwise elected by the Employer (e.g., direct reimbursement by check, automatic deposit via automated clearing house (ACH)).

b) If a Participant agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant, or other independent third party that provides products or services that are eligible for payment of qualifying Benefit expenses as otherwise set forth herein.

1) Within the cardholder agreement, the Participant agrees that payment for qualifying Benefit expenses can only be made on behalf of the Participant, the Participant's Spouse, or other qualifying Dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Participant's signed Election. The Participant also certifies that any expense paid with the Debit Card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The Participant-cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the Debit Card is used. The Participant-cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the Debit Card, including invoices and receipts where appropriate or as required by law. The Participant-cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

2) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall separately adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to, a requirement to maintain the program in compliance with

applicable standards under the Code and any mandates that payments for qualifying expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the Debit Card has been used for qualifying Benefit payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.

3) If the Benefit reimbursement request is being submitted for any non-qualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved independent third party, but shall also require the Participant-cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

4) If a Participant attempts to utilize the Debit Card or other form of electronic payment for any improper or non-allowable purpose, the Participant shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant.

5) If any conditional payment or other Benefit payment has been made but is not deemed to be qualifying Benefit expense reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

   (a) Upon identification of any improper payment, the Administrator shall require the Participant to pay back to the Plan an amount equal to the improper payment;

   (b) If the Participant does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Participant's wages or other Compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;

   (c) To the extent that neither (a) nor (b) above are allowable or effective, the Administrator shall have the authority to utilize a Claim substitution or offset approach to resolve the improper Claim amount(s), with such methodology being clearly explained to the Participant-cardholder as part of their cardholder agreement.

   (d) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by the Participant. The

Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Participant-cardholder agreement.

12.3 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee, and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

12.4 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Plan or by any Trust Fund that may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of Highly Compensated Employees to the extent nondiscrimination laws apply.

12.5 INSURANCE CONTROL CLAUSE

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

12.6 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE XIII
AMENDMENT OR TERMINATION OF PLAN

13.1 AMENDMENT

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

13.2 TERMINATION

By signing the Adoption Agreement, the Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made and no further additions shall be made to the Insurance Benefit program, Healthcare Flexible Spending Account, or Dependent Care Assistance Account. Payments from such account(s)/program(s) shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of Claims), or until the balances of all accounts have been reduced to zero, whichever occurs first. Any amounts remaining in any such account(s)/ program(s) as of the end of the Plan Year in which Plan termination occurs shall be forfeited after the expiration of the Claim filing period. The above notwithstanding, Benefits under any Insurance Contract shall be paid in accordance with the terms of that Contract.

ARTICLE XIV
HIPAA PRIVACY REQUIREMENTS

As of the required Effective Date, the Employer has implemented or amended the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as set forth in 45 C.F.R. Parts 160 through 164;

14.1 DEFINITIONS In addition to the specific definitions set forth below, all other capitalized terms used that are not otherwise defined herein have the meanings ascribed in HIPAA:

a) **“Designated Record Set”** has the meaning in 45 CFR Section 164.501.

b) **“Electronic Media”** has the meaning in 45 CFR Section 160.103, which is:

1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

2) Transmission media used to exchange information already in electronic storage media.

3) Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

c) **"Electronic Protected Health Care Information"** (also known as "ePHI") has the meaning in 45 CFR Section 160.103, and is limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of the Plan.

d) **"Plan Administration Functions"** is defined as activities that would meet the definition of Payment or Healthcare Operations by HIPAA as set forth in 45 C.F.R. Section 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration includes quality assurance, claims processing, auditing, monitoring, and management of carve-out plans (i.e., vision and dental). Plan administration does not include any employment-related functions or functions in connection with any other Benefits or Benefit plans, and the Plan(s) may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by the Employer are not considered Plan Administration Functions.

e) **"PHI"** is defined as Protected Health Information, as set forth in 45 C.F.R. Section 164.501. It is information that is created or received by a health plan, employer, healthcare provider, or healthcare clearing house and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, the information either identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.

f) **"Secretary"** means the Secretary of the Department of Health and Human Services or designee.

g) **"Security Incident"** has the meaning in 45 CFR Section 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

h) **"Summary Health Information"** is defined by HIPAA as set forth in 45 C.F.R. Section 164.504 as information that may be PHI, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under the Plan; and from which the following information has been deleted, except that the geographic information described in 2) need only be aggregated to the level of a five-digit zip code or the initial three digits of a zip code:

1) Names;

2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

   (a) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

   (b) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

4) Telephone numbers;

5) Fax numbers;

6) Electronic mail addresses;

7) Social Security numbers;

8) Medical record numbers;

9) Health plan beneficiary numbers;

10) Account numbers;

11) Certificate/license numbers;

12) Vehicle identifiers and serial numbers, including license plate numbers;

13) Device identifiers and serial numbers;

14) Web Universal Resource Locators (URLs);

15) Biometric identifiers, including finger and voice prints;

16) Full face photographic images and any comparable images; and

17) Any other unique identifying number, characteristic, or code.

14.2 DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan, its Administrator, or any contracted representatives of the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

b) Modifying, amending, or terminating the Plan.

14.3 DISCLOSURE OF PHI

The Plan, its Administrator, or any contracted representatives of the Plan, may release PHI to the Employer, so long as the Employer agrees to do the following:

a) The Employer shall not use or further disclose the PHI other than as permitted or required by the Plan's documents or as required by law;

b) The Employer shall ensure that any agents, including a subcontractor, to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

c) The Employer shall not use or disclose the PHI for employment-related actions and decisions, or in connection with any other Benefit or employee Benefit plan of the Employer;

d) The Employer agrees to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures providing herein, if and when the Employer becomes aware of such inconsistent use or disclosure;

e) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals;

f) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals for amendment and to incorporate such amendments of PHI;

g) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.528 and consistent with the Employer Privacy Policy, has authorized the

Plan to make available the information required to provide an accounting of disclosures;

h) The Employer, agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA;

i) If feasible, the Employer shall return or destroy all PHI that the Employer received from the Plan and which the Employer no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;

j) The Employer agrees to use appropriate safeguards to prevent unauthorized use or disclosure of PHI, and have reasonable and appropriate safeguards in place to protect the confidentiality, integrity and availability of ePHI;

k) The Employer agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;

l) The Employer agrees to report to the Plan, any use or disclosure of PHI of which it becomes aware that is not permitted or required by HIPAA; and

m) The Employer agrees to report to the Plan any Security Incident of ePHI of which it becomes aware.

14.4 ADEQUATE SEPARATIONS

The Employer shall ensure that the following adequate separations are established:

a) The Employer shall designate specific people who shall use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions.

b) Access and use of PHI by the Group shall be limited to Plan Administration Functions that the Employer performs on behalf of the Plan;

c) Any issues of noncompliance by the Group shall result in disciplinary measures specified in the Employer Privacy Policy.

14.5 USES AND DISCLOSURES

The Plan, its Administrator, or any contracted representatives of the Plan, may:

a) Disclose PHI to the Employer in order for the Employer to carry out Plan Administration Functions consistent with the provisions of Subsections a) through i) and Subsection 14.4 above;

b) Permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Employer, so long as the disclosure is made to an authorized person, and the disclosure is only for the purpose described in this Section 14.5;

c) Not disclose or permit an insurance, insurance service, insurance organization, or HMO to disclose PHI to the Employer unless the Employer's privacy notice contains a provision which permits such disclosure; and

d) Not disclose PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee Benefit plan of the Employer.

ARTICLE XV
MISCELLANEOUS

15.1 PLAN INTERPRETATION

a) All provisions of this Plan shall be governed and interpreted by the Administrator in its full and complete discretion and shall be otherwise applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 15.12.

b) In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of the Administrators of the plans for any Insurance Benefits selected as part of Paragraph 8 of the signed Adoption Agreement, or by accountants, counsel, or other experts employed or engaged by the Administrator.

15.2 GENDER AND NUMBER

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

15.3 WRITTEN DOCUMENT

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

15.4 EXCLUSIVE BENEFIT

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

15.5 PARTICIPANT'S RIGHTS

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

15.6 ACTION BY THE EMPLOYER

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

15.7 EMPLOYER'S PROTECTIVE CLAUSES

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

b) The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a Claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise, or refuse to pursue the Claim as the Participant, in their sole discretion, shall see fit.

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

15.8 NO GUARANTEE OF TAX CONSEQUENCES

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

15.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

15.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

15.11 GOVERNING LAW

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

15.12 SEVERABILITY

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

15.13 CAPTIONS

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

15.14 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, in the event any Benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

15.15 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS (USERRA) ACT

Notwithstanding any provision of this Plan to the contrary, contributions, Benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

15.16 GENETIC INFORMATION NONDISCRIMINATION ACT

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

15.17 MENTAL HEALTH PARITY AND ADDICTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712. Specifically, as of January 1, 2010, the Plan shall no longer apply a specific annual or lifetime maximum coverage limitation, daily visit limitation or separate per day limit on coverage or services for mental and nervous disorders and/or substance abuse that is different from any other inpatient or outpatient treatment provided for under the Plan, and coverage shall be provided the same as any other medical procedure.

15.18 WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

15.19 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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