

**SUBMITTAL TO THE BOARD OF SUPERVISORS  
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

910



**FROM:** Human Resources Dept.

**SUBMITTAL DATE:**  
December 1, 2005

**SUBJECT:** Amendment to Flexible Benefits Program

**RECOMMENDED MOTION:** 1) Approve the amended Flexible Benefit Program, Dependent Care Reimbursement Plan and Health Care Reimbursement Plan as outlined in Attachments A, B, and C; 2) Authorize the Chairperson to sign four (4) copies of the attached Amendments and; 3) retain one (1) copy of the signed Amendments and return three (3) copies to Human Resources for distribution.

**BACKGROUND:** The Flexible Benefits Program was first adopted on November 20, 1986, to allow employees to elect among various non-taxable benefits and cash compensation. The Internal Revenue Service (IRS) issued Notice 2005-42 (Exhibit 1) in July 2005, which permits employers to adopt a two and one-half month temporary grace period immediately following the end of each plan year. During this grace period, all or a portion of the unused contributions remaining at the end of the prior plan year may be used to reimburse participants for qualified benefit expenses incurred through March 15<sup>th</sup>.

FORM APPROVED  
COUNTY COUNSEL

DEC 1 2005  
Departmental Concurrence

*Homer*

*[Signature]*

Ronald W. Komers  
Asst. County Executive Officer/Human Resources Dir.

<b>FINANCIAL DATA</b>	Current F.Y. Total Cost:	\$ 0	In Current Year Budget:	Yes
	Current F.Y. Net County Cost:	\$ 0	Budget Adjustment:	No
	Annual Net County Cost:	\$ 0	For Fiscal Year:	2005/2006

<b>SOURCE OF FUNDS:</b> FSA payroll deductions	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input type="checkbox"/>

**C.E.O. RECOMMENDATION:**

**APPROVE**

**County Executive Office Signature**

*[Signature]*

- Consent
- Policy
- Consent
- Policy

Dep't Recomm.:  
Per Exec. Ofc.:

**Prev. Agn. Ref.:** | **District:** | **Agenda Number:**

COUNTY OF RIVERSIDE  
02 DEC -1 6M 5:38  
OFFICE EXECUTIVE

**3.13**

**BACKGROUND continued**

The Flexible Spending Account, Dependent Care, and Health Care plan documents (Attachments A, B and C) have been amended to incorporate the grace period provision, for up to \$5,000 of unused balances, for each plan. The establishment of the \$5,000 limit will minimize County exposure for loss, reduce participant forfeitures and encourage greater employee participation in the future. The plan amendments are required by December 31, 2005, to be applied to the 2005 plan year. Current participants will receive a notice explaining the change.

The plan documents have also been amended to reflect current regulations. These changes include updating mid-year status change provisions, adding the Health Insurance Portability and Accountability Act (HIPAA) privacy statement, adding Family Medical Leave Act (FMLA) rights, clarifying tax liability to employees, establishing claim review guidelines which conform to industry standards and clarifying current administrative practices.

The plan documents have been reviewed and approved by County Counsel.

---

**THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM**

---

## TABLE OF CONTENTS

ARTICLE I INTRODUCTION.....	1
1.1 Creation and Title.....	1
1.2 Effective Date.....	1
1.3 Purpose.....	1
ARTICLE II DEFINITIONS.....	2
ARTICLE III PARTICIPATION.....	5
3.1 Eligibility.....	5
3.2 Commencement of Participation.....	5
3.3 Term of Participation.....	6
3.4 Participation by Rehired Employees.....	6
3.5 HIPAA Portability.....	6
3.6 COBRA Continuation Coverage.....	6
3.7 Family Medical Leave Act.....	6
ARTICLE IV CONTRIBUTIONS.....	8
4.1 Source of Contributions.....	8
4.2 Spending Credits.....	8
4.3 Change in Participant's Benefits Enrollment.....	8
4.4 Increases or Decreases in Premiums.....	9
4.5 Maximum Contribution.....	9
4.6 Nondiscrimination.....	9
4.7 Tax Treatment.....	9
ARTICLE V PARTICIPANTS' ACCOUNTS AND PAYMENT OF BENEFITS.....	10
5.1 Participants' Benefit Accounts.....	10
5.2 Premium Account.....	10
5.3 Reimbursement Account.....	10
5.4 Payment of Benefits.....	10
5.5 Coverage Provided.....	10
ARTICLE VI PLAN ADMINISTRATION.....	11
6.1 Plan Administrator.....	11
6.2 Plan Administrator's Duties.....	11
6.3 Information to be Provided to Plan Administrator.....	11
6.4 Decision of Plan Administrator Final.....	12
6.5 Review Procedures.....	12

6.6	Extensions of Time.....	12
6.7	Rules to Apply Uniformly.....	12
6.8	Indemnity.....	13

**ARTICLE VII GENERAL PROVISIONS ..... 14**

7.1	Amendment and Termination.....	14
7.2	Nonassignability.....	14
7.3	Medical Child Support Orders.....	14
7.4	Not an Employment Contract.....	15
7.5	Participant Litigation.....	15
7.6	Addresses, Notice and Waiver of Notice.....	15
7.7	Required Information.....	15
7.8	Severability.....	15
7.9	Gender and Number.....	15
7.10	Applicable Laws.....	15

# THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

## ARTICLE I INTRODUCTION

### 1.1 Creation and Title.

The County of Riverside, a political subdivision of the State of California (the "County"), hereby amends its cafeteria plan under the terms and conditions set forth in this document. The Plan is to be known as The County of Riverside Flexible Benefit Program.

### 1.2 Effective Date.

The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2005. The Plan was originally effective November 20, 1986.

### 1.3 Purpose.

The purpose of the Plan is to allow Employees to select among cash compensation and certain nontaxable benefits, namely coverage under one or more benefits programs maintained by the County as Employer. The County intends that the Plan qualify as a cafeteria plan under section 125 of the Code, and that the Benefits provided under the Plan be eligible for exclusion from Federal income tax.

# THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

## ARTICLE II DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

**2.1 "Benefits"** mean cash and the various qualified benefits under section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including but not limited to health plans, dental plans, vision plans, and health care reimbursement and dependent care reimbursement benefits.

**2.2 "Benefits Accounts"** mean the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

**2.3 "Benefits Enrollment Application"** means the completion of paper forms and/or submission of electronic enrollment, including a Salary Reduction Agreement, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.

**2.4 "Code"** means the Internal Revenue Code of 1986, as amended from time to time, or superseded by laws of similar effect.

**2.5 "Compensation"** means all the earned income, salary, wages and other earnings except bonuses and overtime paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a Salary Reduction Agreement which are not includable in gross income under sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

**2.6 "Dependent"** means an individual who is a dependent within the meaning of section 152(a) of the Code and modified by Code sections 105 and 106 and the respective Regulations thereunder, of a Participant or a former Participant in the Plan. Notwithstanding the previous sentence, with respect to Dependent Care Reimbursement Benefits, "Dependent" shall have the meaning as set forth in the County of Riverside Dependent Care Reimbursement Plan.

**2.7 "Effective Date"** The provisions of the Plan, originally effective as of November 20, 1986, have been amended and restated, effective as of January 1, 2005.

**2.8 "Eligible Employee"** means an Employee, as defined in section 2.9 below, who has met the Eligibility requirements of the Plan set out in section 3.1.

**2.9 "Employee"** means an individual employed by the Employer in a regular position, as defined in Salary Ordinance Number 440 of the County. The term Employee excludes per diem, temporary and seasonal employees, as defined in Salary Ordinance Number 440 of the County, leased employees as defined in Code section 414(n), and each individual whom the County treats as an independent contractor, even if s/he might otherwise satisfy certain of the legal tests or criteria to be considered a common law employee of the County.

THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

**2.10 "Employer" and "County"** means the County of Riverside, a political subdivision of the State of California, or any of its affiliates, successors or assignors which adopt the Plan.

**2.11 "Entry Date"** means, for each Eligible Employee, the first day that the Employee becomes eligible to participate in the Plan.

**2.12 "Participant"** means any Employee who has met the eligibility requirements of section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Salary Reduction Agreement and Benefits Enrollment Application.

**2.13 "Plan"** means The County of Riverside Flexible Benefit Program, as described herein.

**2.14 "Plan Administrator"** means the Human Resources Director of the County, or such other person or committee as may be appointed by the Employer to administer the Plan.

**2.15 "Plan Year"** means the 12-consecutive month period beginning on January 1 and ending on December 31.

**2.16 "Regulation"** means any applicable regulation established by the U.S. Treasury that relate to benefit plans established under Code section 125.

**2.16 "Salary Reduction Agreement"** means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of making contributions toward Benefits under the Plan.

**2.17 "Spending Credits"** mean an amount made available to a Participant by the Employer in a Plan Year for use in purchasing Benefits available under the Plan.

**2.18 "Spouse"** means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

**2.19 "Status Change"** means any of the following with respect to Benefits under the Plan:

- (a) Legal marital status. Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption.
- (c) Employment status. Any of the following events that change the employment status of the Employee, Spouse, or a Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer or the employer of a 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 paragraph.

## THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

- (d) Dependent first satisfies or ceases to satisfy eligibility requirements. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) Residence. A change in the place of residence of the Employee, Spouse or Dependent.
- (f) Judgment, decree, or order. This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in section 609 of ERISA) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code section 152 (except that any child to whom Code section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan; or permit the Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child.
- (g) Entitlement to Medicare or Medicaid. If an Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Employee to make a prospective election change to cancel or reduce coverage of that Employee or Dependent under the Plan. In addition, if an Employee, Spouse or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Employee to make a prospective election to commence or increase coverage of that Employee, Spouse or Dependent under the Plan.
- (h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code section 125.

**ARTICLE III  
PARTICIPATION**

**3.1 Eligibility.**

Each Employee, as defined in section 2.9 above, who is a member of a group of Employees which is:

- (a) represented for collective bargaining purposes by an association or union which adopts the Plan through a Memorandum of Understanding with the County, or
- (b) within a classification of Employees with respect to which the County adopts the Plan, shall be eligible to participate in the Plan if the Employee is eligible to participate in the Employer's health care program and so long as the Participant is employed by the Employer as of his or her Entry Date. If a Participant transfers to any position which is not covered by the Plan, s/he will cease to be a Participant. The individual will again be eligible to become a Participant when s/he returns to a position covered by the Plan.

**3.2 Commencement of Participation.**

An Eligible Employee shall become a Participant in the Plan after completing the Plan Administrator's executed Benefits Enrollment Application setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year or, with respect to an Employee's initial election period, the remaining portion of the Plan Year that contains the Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. An Eligible Employee must execute the Plan Administrator's Benefit Enrollment Application and a Salary Reduction Agreement, within 60 days of the Entry Date. Notwithstanding the above, any employee who fails to enroll in a medical plan sponsored by the County as required by his/her Memorandum of Understanding or Management Resolution will be automatically enrolled in County sponsored medical plan and will be deemed to have elected participation in this Plan without a Benefit Enrollment Application. A Participant may not modify his Benefits elections at any time during the Plan Year except as provided for under Section 4.3. If a Participant wants to change his elections for a forthcoming Plan Year, the Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Application, which may be completed in paper or electronic form. Each new Benefits Enrollment Application shall specify the type and amount of Benefits to be made available to the Participant for the immediately following Plan Year.

Should a Participant fail to execute a valid Benefit Enrollment Application for any Plan Year before the start of the Plan Year, the Benefits Enrollment Application for the immediately preceding Plan Year shall be deemed to be effective for the subsequent Plan Year. In addition, the Participant shall be deemed to have executed a valid Benefits Enrollment Application for purposes of determining the source and amount of contributions to the Plan pursuant to Article IV of the Plan. A Participant may also elect not to participate for a particular Plan Year by submitting an "Election to Pay Premiums with After-Tax Dollars" form prior to the start of the Plan Year. Notwithstanding the above, a Participant who fails to execute a valid Benefits Enrollment Application for any Plan Year before the start of the Plan Year with respect to participation in the County's Health Reimbursement Plan or Dependent Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

**3.3 Term of Participation.**

Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

- (a) the end of the month following the month in which the Participant ceases to be an Employee, resigns or terminates employment with the Employer, subject to the provisions of section 3.4;
- (b) the date the Participant fails to make required contributions under the Plan;
- (c) the date the Participant dies; or
- (d) the date the Plan terminates.

**3.4 Participation by Rehired Employees.**

If a terminated Employee is rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may resume participation in the Plan under the terms of the Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year.

**3.5 HIPAA Portability.**

Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Insurance Portability and Accountability Act of 1996("HIPAA") for coverage by an accident or health benefit under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

**3.6 COBRA Continuation Coverage.**

Subject to any provision in the Code or Regulations governing COBRA Continuation Coverage to the contrary, COBRA type continuation shall be available to all Participants. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

**3.7 Family Medical Leave Act.**

Subject to any provision in the Code or Regulations governing Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave coverage to the contrary, FMLA-type continuation coverage shall be available to all qualifying Participants.

If the leave is paid, contributions may continue to be made under the Plan as elected under Section 3.2. Payment Options for coverage while on unpaid leave include:

- (a) Pre-pay before commencement of leave through pre-tax or after-tax Salary Reduction Agreement from any taxable Compensation, provided all other Plan requirements are met; or

## THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

- (b) Pay-as-you-go. Employees may pay their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations and approved by the Plan Administrator.

If an Employee is away from work during an approved non-FMLA absence without pay, any of the above options may also be allowed.

The Employer shall not be required to continue the coverage of an Employee who fails to make required premium payments while on FMLA, CFRA or other leave. However, if the Employer chooses to continue the coverage of an Employee who fails to make required premium payment while on leave, the Employer is entitled to recoup those payments after the Employee returns from leave.

# THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

## ARTICLE IV CONTRIBUTIONS

### **4.1 Source of Contributions.**

The Employer shall contribute amounts deemed necessary to meet its obligations under the Plan. Contributions to the Plan for the Plan Year shall include amounts determined by the Benefits Enrollment Application entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in such accounts or funds as the Employer deems appropriate.

### **4.2 Spending Credits.**

Prior to the beginning of each Plan Year or a Participant's Entry Date, the Employer shall provide each Participant with an amount of Spending Credits according to the formula set forth by the Board of Supervisors prior to the beginning of the Plan Year. Each Participant shall select from among the Benefits (other than cash compensation) available under the Plan and apply Spending Credits towards the cost of the selected Benefits by either completing a Benefits Enrollment Application in paper form and returning it to the Plan Administrator, or completing an online enrollment Application. Spending Credits not applied by the Participant toward the cost of Benefits shall be paid as cash compensation, and only if the Participant elects at least one of the Benefits options and submits a Benefits Enrollment Application to the Plan Administrator. Employees electing not to take medical coverage are not eligible to receive Spending Credits unless they meet the rules regarding waiver eligibility stipulated in the Memorandum of Understanding or Management/Confidential Resolution governing their bargaining unit. They must also provide evidence of medical coverage through their Spouse or other sources, and sign a statement that they are enrolled and covered under another medical plan, within 60 days of election.

The County shall provide a composite contribution for each Employee in the amount determined by the Board of Supervisors, based on the Employee's unit/classification. Included within the monthly contribution amount is an amount that is designated as the County's monthly contribution toward the Public Employees' Medical Health Care Act (PEMHCA) or the County's optional health plans, if any.

### **4.3 Change in Participant's Benefits Enrollment.**

No Participant shall be allowed to alter or discontinue the Participant's elected Benefits under the Plan during a Plan Year except when due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively (except for the retroactive enrollment right under Code section 9801 (f) that applies to a timely election made after a birth, adoption, or placement of a child for adoption), and apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Application.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment

## THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

period. With respect to any other change in election, "timely submitted" shall mean submitted no later than 60 days from the date of the qualifying Status Change. The Plan Administrator shall make the final determination regarding whether the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and Benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of this Plan.

#### **4.4 Increases or Decreases in Premiums.**

Should a third party benefit provider, such as an Insurance Company, increase or decrease premiums for any health benefits being offered under this Plan during the Plan Year, any Participant participating in such benefit shall have his contributions increased or decreased automatically in an amount sufficient to pay for such increase or decrease. However, in the case of a significant increase in premium, if there is a similar benefit offered under the Plan at the time of said increase at a lower cost, the Participant may select such similar benefit rather than pay the increase.

#### **4.5 Maximum Contribution.**

The Maximum Contribution any individual can make under this Plan is an amount equal to the sum of the costs for each of the highest cost premium-type Benefit Options offered under the Plan in each Benefit Category plus the sum of the deferrals made to Reimbursement-type Benefit programs under this Plan. The term "Benefit Option" refers to any category of Benefits offered under this Cafeteria Plan in which the Participant has the opportunity to choose one benefit from several different Benefit Options in that category. The term "Benefit Category" refers to any category of Benefits offered under this Plan and may include (but is not limited to) Health plans (Medical, Dental, and Vision), Flexible Spending Accounts (Health Care and Dependent Care), Group Term Life Insurance or Disability Insurance.

#### **4.6 Nondiscrimination.**

The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated individuals from participation in the Plan or limiting the contributions made with respect to certain highly compensated participants if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

#### **4.7 Tax Treatment.**

While it is County's intent that nontaxable Benefits will be eligible for exclusion from the gross income of the Employee, the County cannot guarantee or ensure that any of the Benefits provided under the Plan will not be subject to income or other taxes.

Furthermore, the County will not be liable for any income or other taxes imposed upon an Employee, Spouse, Dependent, or any other person by reason of any Benefits received under the Plan.

**ARTICLE V**  
**PARTICIPANTS' ACCOUNTS AND PAYMENT OF BENEFITS**

**5.1 Participants' Benefit Accounts.**

The Plan Administrator shall establish separate Benefits Accounts based on the Benefits selections made by each Participant. Contributions shall be credited to the proper Benefits Accounts of each Participant. Each Benefits Account shall be designated as a "Premium Account" or as a "Reimbursement Account".

**5.2 Premium Account.**

A "Premium Account" is an account established with the intent of paying for premium-type Benefits pursuant to an insurance policy issued by an insurance company, or a contract with a health maintenance, preferred provider, or point of service organization to provide medical, dental, vision, psychological or psychiatric, prescription drugs, or other qualified benefits under Code section 125.

**5.3 Reimbursement Account.**

A "Reimbursement Account" is an account established with the intent of providing reimbursement of allowable expenses pursuant to a health care or dependent care reimbursement plan offered by the Employer.

**5.4 Payment of Benefits.**

The Plan Administrator shall pay the Benefits authorized under the Plan other than insurance benefits administered by a third-party benefit provider. Payment shall be made by the Employer (or the designated Plan Administrator), in a timely manner upon receipt of a premium notice from the Benefit provider providing such Benefit. In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

- (a) Executor of the Estate of the deceased Participant,
- (b) Spouse,
- (c) Family member held responsible for payment of deceased's medical bills,
- (d) Spouse of dependent with COBRA continuation rights.

**5.5 Coverage Provided.**

The provisions of each health, dental, and vision Benefit Option available under this Plan are described in the individual benefit plan descriptions. Reimbursement-type benefits are described in separate plan documents.

**ARTICLE VI  
PLAN ADMINISTRATION**

**6.1 Plan Administrator.**

The Plan Administrator shall be responsible for the administration of the Plan.

**6.2 Plan Administrator's Duties.**

In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have such rights, duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

- (a) to construe and interpret the Plan, to decide all questions of eligibility and participation, and to determine the benefit plans and programs to be covered by this plan;
- (b) to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;
- (c) to prescribe and apply any rules or procedures to insure the orderly and efficient administration of the Plan, including procedures for making or changing elections;
- (d) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;
- (e) to develop appellate and review procedures for any Participant, Spouse, Dependent or designated beneficiary denied benefits under the Plan;
- (f) to prepare and distribute information explaining this Plan and the benefit plans and programs covered hereby in such manner as the Plan Administrator deems to be appropriate;
- (g) to request and receive from all Participants such information as the Plan Administrator shall determine to be necessary for the proper administration of this Plan;
- (h) to furnish each Participant with such reports as the Plan Administrator deems to be reasonable and appropriate;
- (i) to receive, review, and keep on file such reports and information concerning the benefit plans and programs covered by this Plan as the Plan Administrator determines to be necessary and proper;
- (j) to appoint or employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing.

The Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of section 125 of the Code.

**6.3 Information to be Provided to Plan Administrator.**

The Employer, or any of its agents, shall provide to the Plan Administrator any employment

records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant, Spouse or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

**6.4 Decision of Plan Administrator Final.**

Subject to applicable state or Federal law, and the provisions of section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

**6.5 Review Procedures.**

In cases where the Plan Administrator denies a Benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive Benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of Benefits. The written denial shall be provided to the party within 30 days of the date the Benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

**6.6 Extensions of Time.**

In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

**6.7 Rules to Apply Uniformly.**

The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

ARTICLE VII  
GENERAL PROVISIONS

**6.8 Indemnity.**

The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law, any employee of the Employer designated by the Employer or the Plan Administrator to assist in the fulfillment of the administration of this Plan, against claims resulting from any action or conduct relating to such administration, except for claims arising from gross negligence, willful neglect, or willful misconduct. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties relating to such actions, over and above those paid by any liability or insurance contract.

**ARTICLE VII  
GENERAL PROVISIONS**

**7.1 Amendment and Termination.**

The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any Benefit a Participant, Spouse, Dependent or designated beneficiary was or might have been entitled to under the Plan prior to the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with section 125 of the Code or any other provision of the Code applicable to the Plan.

**7.2 Nonassignability.**

Any Benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and designated beneficiaries. No Benefit shall be voluntarily or involuntarily assigned, sold or transferred.

**7.3 Medical Child Support Orders.**

The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which:

- I. Relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;
- II. Is made pursuant to a state domestic relations law; and
- III. Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the plan.

Any such Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Upon determination of a QMCSO, the Plan must recognize the QMCSO by providing benefits for

the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

**7.4 Not an Employment Contract.**

By creating this Plan and providing Benefits under the Plan, the Employer in no way guarantees employment for any Employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

**7.5 Participant Litigation.**

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

**7.6 Addresses, Notice and Waiver of Notice.**

Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

**7.7 Required Information.**

Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

**7.8 Severability.**

In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

**7.9 Gender and Number.**

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

**7.10 Applicable Laws.**

The Plan is governed by the Code and the Regulations issued thereunder (as they might be amended from time to time). 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 of California.

THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

The Participant's child in accordance with such order and shall remain the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

7.4 Not an Employment Contract

By creating the Plan and granting benefits under the Plan, the Employer and the Participant do not intend to create an employment contract for any Employee or Participant under the Plan. The Participant's participation in the Plan shall in no way assure continued employment with the Employer.

Employer: COUNTY OF RIVERSIDE

7.5 Participant Litigation

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or superseded shall be binding on the Employer and any interested party to the Plan.

Chairman, Board of Supervisors

7.6 Addressee, Notice and Waiver of Notice

Each Participant shall furnish the Employer with his current post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to seek out or investigate the whereabouts of any person failing to furnish the Plan. Any notice required under the Plan may be waived by such person enrolled to such notice.

7.7 Required Information

Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable for the efficient operation and administration of the Plan and for the protection of the Employer.

FORM APPROVED  
COUNTY COUNSEL

DEC 1 2005

7.8 Severability

In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not affect the validity of any other provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provisions had never existed under the Plan.

BY [Signature]

7.9 Gender and Number

Except where otherwise indicated by the context, any masculine term used in this Plan shall also include the feminine and the neuter gender, and the singular shall also include the plural.

7.10 Applicability

The Plan is governed by the Code and the Regulations issued thereunder. In any event, the Plan shall be construed, interpreted and administered according to the laws of the State of California.

---

**THE COUNTY OF RIVERSIDE  
DEPENDENT CARE REIMBURSEMENT PLAN**

---

## TABLE OF CONTENTS

ARTICLE I INTRODUCTION.....	1
1.1 Creation and Title.....	1
1.2 Effective Date.....	1
1.3 Purpose.....	1
ARTICLE II DEFINITIONS.....	2
ARTICLE III PARTICIPATION.....	6
3.1 Eligibility.....	6
3.2 Commencement of Participation.....	6
3.3 Term of Participation.....	6
3.4 Participation by Rehired Employees.....	6
3.5 Family Medical Leave Act.....	7
ARTICLE IV BENEFITS.....	8
4.1 Provision of Benefits.....	8
4.2 Amount of Reimbursement.....	8
4.3 Change in Participant Election.....	8
4.4 Nondiscriminatory Benefits.....	8
4.5 Tax Treatment.....	8
4.6 Maximum Benefits.....	9
ARTICLE V FUNDING AND PAYMENT OF BENEFITS.....	10
5.1 Funding.....	10
5.2 Participants' Accounts and Account Balances.....	10
5.3 Payment of Benefits.....	10
5.4 Forfeiture of Benefits.....	11
5.5 Dependent Care Credit Under Federal Income Tax.....	11
5.6 Annual Report to Participants.....	11
ARTICLE VI PLAN ADMINISTRATION.....	12
6.1 Plan Administrator.....	12
6.2 Plan Administrator's Duties.....	12
6.3 Information to be Provided to Plan Administrator.....	12
6.4 Decision of Plan Administrator Final.....	13
6.5 Review Procedures.....	13
6.6 Extensions of Time.....	13
6.7 Rules to Apply Uniformly.....	13
6.8 Indemnity.....	13

TABLE OF CONTENTS

**ARTICLE VII GENERAL PROVISIONS ..... 15**

7.1 Amendment and Termination ..... 15

7.2 Nonassignability ..... 15

7.3 Not an Employment Contract ..... 15

7.4 Participant Litigation ..... 15

7.5 Addresses, Notice and Waiver of Notice ..... 15

7.6 Required Information ..... 15

7.7 Severability ..... 15

7.8 Applicable Laws ..... 16

ARTICLE IV BENEFITS

4.1 Eligibility ..... 16

4.2 Commencement of Participation ..... 16

4.3 Term of Participation ..... 16

4.4 Participation by Retired Employees ..... 16

4.5 Family Medical Leave Act ..... 16

4.6 Provision of Benefits ..... 16

4.7 Amount of Retirement ..... 16

4.8 Change in Participant Election ..... 16

4.9 Nondiscriminatory Benefits ..... 16

4.10 Tax Treatment ..... 16

4.11 Maximum Benefits ..... 16

ARTICLE V FUNDING AND PAYMENT OF BENEFITS

5.1 Funding ..... 17

5.2 Participant Accounts and Account Balances ..... 17

5.3 Payment of Benefits ..... 17

5.4 Forfeiture of Benefits ..... 17

5.5 Dependent Care Credit Under Federal Income Tax ..... 17

5.6 Annual Report to Participants ..... 17

ARTICLE VI PLAN ADMINISTRATION

6.1 Plan Administrator ..... 18

6.2 Plan Administrator's Duties ..... 18

6.3 Information to be Provided to Plan Administrator ..... 18

6.4 Decision of Plan Administrator Final ..... 18

6.5 Review Procedures ..... 18

6.6 Extension of Time ..... 18

6.7 Rules to Apply Uniformly ..... 18

6.8 Indemnity ..... 18

**ARTICLE I  
INTRODUCTION**

**1.1 Creation and Title.**

The County hereby amends its welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as The County of Riverside Dependent Care Reimbursement Plan.

**1.2 Effective Date.**

The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2005. The Plan was originally effective January 1, 2000.

**1.3 Purpose.**

The purpose of the Plan is to provide reimbursement for certain dependent expenses of the Participants not otherwise covered by insurance or by the County as Employer. The County intends that the Plan qualify as a dependent care assistance plan under section 129(d) of the Code, and that the benefits provided under the Plan be eligible for exclusion from Participants' income under section 129 of the Code.

## ARTICLE II DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

**2.1 “Agreement to Participate”** means the agreement evidencing an Eligible Employee’s election to participate in the Plan and setting forth the amount of Dependent Care Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Dependent Care Expenses.

**2.2 “Benefits Enrollment Application”** means the completion of paper forms and/or submission of electronic enrollment in which an Eligible Employee selects from the various benefits sponsored by the Employer, including coverage under the Plan. The Benefits Enrollment Application shall set forth the amount of Dependent Care Reimbursement Benefits to be made available for a Plan Year or portion of a Plan Year as reimbursement for Dependent Care Expenses.

**2.3 “Code”** means the Internal Revenue Code of 1986, as amended from time to time.

**2.4 “Compensation”** means all earned income, salary, wages, and other earnings except bonuses and overtime paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a Salary Reduction Agreement which are not includable in gross income under sections 125, 402(g)(3), 402(h), 403(b), or 457(b) of the Code.

**2.5 “Dependent”** means a Participant’s:

- (a) Dependent child (as defined under Code section 152(a)(1)) of the Participant who is under the age of thirteen,
- (b) Spouse, if the Spouse is physically or mentally incapable of self-care and who lives in the same household as the Participant for more than one-half of a Plan Year, or
- (c) Other dependent (not described in paragraph (a) or (b)) of the Participant who is physically or mentally incapable of self-care and who lives in the same household as the Participant for more than one-half of a Plan Year.

These individuals must depend on the Participant for over one-half of their support. Furthermore, with respect to paragraphs (b) and (c), a Dependent must also regularly spend at least eight hours a day in a Participant’s home for purposes of incurring Dependent Care Expenses outside the home.

An individual shall not be treated as having the same principle place of abode of the Participant if at any time during the Plan Year of the Plan Participant the relationship between the individual and the Plan Participant is in violation of local law.

In the case of a divorced or separated Participant when Code section 152(e)(1) (special rule for divorced parents) is applicable and the requirements of Code section 152(e)(2) are satisfied in

connection with a child of the Participant; then such a child shall be treated as being the “qualifying child” or “qualifying relative” (as defined by Code section 152) of the noncustodial parent.

**2.6 “Dependent Care Expenses”** mean expenses incurred during a Plan Year by a Participant for the care of a Dependent of the Participant for related household services which would be considered employment-related expenses under section 21(b)(2) of the Code, and which are eligible for reimbursement from a Participant’s Dependent Care Reimbursement Benefits Account in accordance with the requirements of Code section 129.

**2.7 “Dependent Care Reimbursement Benefits”** means, for any Plan Year, the amount available to a Participant as benefits in the form of reimbursements of Dependent Care Expenses.

**2.8 “Dependent Care Reimbursement Benefits Account”** means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Dependent Care Expenses shall be paid.

**2.9 “Effective Date”** of the Plan, as amended and restated, shall be January 1, 2005.

**2.10 “Eligible Employee”** means an Employee, as defined in section 2.12 below, who has met the eligibility requirements of the Plan set out in section 3.1.

**2.11 “Employee”** means an individual who is a “regular employee”, as defined in Salary Ordinance No. 440 of the County. The term Employee excludes per diem, temporary and seasonal employees, as defined in Salary Ordinance Number 440 of the County, leased employees as defined in Code section 414(n), and each individual whom the County treats as an independent contractor, even if s/he might otherwise satisfy certain of the legal tests or criteria to be considered a common law employee of the County.

**2.12 “Employer” or “County”** means The County of Riverside, a political subdivision of the State of California, and any of its affiliates, successors, or assignors which adopt the Plan.

**2.13 “Entry Date”** means for each Eligible Employee, the first day of the month coincident with the day that the Employee becomes eligible to participate in the Plan.

**2.14 “Participant”** means any Employee who has met the eligibility requirements of section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Agreement to Participate and Salary Reduction Agreement and Benefits Enrollment Application.

**2.15 “Plan”** means The County of Riverside Dependent Care Reimbursement Plan, as described herein.

**2.16 “Plan Administrator”** means the Human Resources Director or such other person or committee as may be appointed by the Human Resources Director to administer the Plan.

**2.17** "**Plan Year**" means the twelve (12) consecutive month period beginning on January 1<sup>st</sup> and ending December 31<sup>st</sup>.

**2.18** "**Regulation**" means any applicable regulation established by the U.S. Treasury that relates to benefit plans established under the Code.

**2.19** "**Salary Reduction Agreement**" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Dependent Care Reimbursement Benefits under the Plan.

**2.20** "**Spouse**" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

**2.21** "**Status Change**" means any of the following with respect to Plan benefits:

- (a) Legal marital status. Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption.
- (c) Employment status. Any of the following events that change the employment status of the Employee, Spouse, or a Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer or the employer of a 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 paragraph.
- (d) Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) Residence. A change in the place of residence of the Employee, Spouse or Dependent.
- (f) Judgment, decree, or order. This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in section 609 of ERISA) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code section 152 (except that any child to whom Code section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan; or permit the Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child.

- (g) Entitlement to Medicare or Medicaid. If an Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Employee to make a prospective election change to cancel or reduce coverage of that Employee or Dependent under the Plan. In addition, if an Employee, Spouse or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Employee to make a prospective election to commence or increase coverage of that Employee, Spouse or Dependent under the Plan.
- (h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

## **ARTICLE III PARTICIPATION**

### **3.1 Eligibility.**

Each Employee, as defined in section 2.11 above, shall be eligible to participate in the Plan if:

- (a) the Employee is eligible to participate in the County of Riverside Flexible Benefit Program; and
- (b) if the Employee is represented for collective bargaining purposes by an association or union, that association or union adopts this Plan through a memorandum of understanding with the County.

### **3.2 Commencement of Participation.**

An Eligible Employee shall become a Participant in the Plan after completing the Plan Administrator with a Benefits Enrollment Application setting forth the amount of Dependent Care Reimbursement Benefits to be made available to the Eligible Employee for the immediately following Plan Year or, with respect to an Eligible Employee's initial election period, the remaining portion of the Plan Year which contains the Eligible Employee's Entry Date. The Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Application. Each such new agreement shall specify the amount to be made available to the Participant for the immediately following Plan Year. Should a Participant fail to execute a valid Benefits Enrollment Application for any Plan Year before the start of the Plan Year, that Participant will be deemed to have elected not to participate for that Plan Year.

### **3.3 Term of Participation.**

Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

- (a) the date the Participant dies, resigns, or terminates employment with the Employer, subject to the provisions of section 3.4;
- (b) the date the Participant fails to make the required contributions under the Plan;
- (c) the date the Participant ceases to be an Employee; or,
- (d) the date the Plan terminates.

A Participant's Dependent Care Reimbursement Benefits Account will remain open for the remainder of the Plan Year in which termination occurs, but ONLY for reimbursement of Dependent Care Expenses incurred prior to the Participant's termination date.

### **3.4 Participation by Rehired Employees.**

If a terminated Employee is rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may elect to resume participation in the Plan under the terms of the Salary Reduction Agreement and Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year.

### **3.5 Family Medical Leave Act.**

Subject to any provision in the Code or Regulations governing Family Medical Leave Act (FMLA) coverage to the contrary, FMLA-type continuation coverage shall be available to all qualifying Participants.

If the leave is paid, contributions may continue to be made under the Plan as elected under Section 3.2. Payment options for coverage while on unpaid leave include the following:

- (a) Pre-pay before commencement of leave through pre-tax Salary Reduction Agreement from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met.
- (b) Pay as you go option. Participants may pay their share of Health Care Reimbursement Benefits on an after-tax basis on the same schedule as payments would be made if the employee were not on leave, or on a pre-tax basis to the extent that the contributions are made from taxable compensation, including cashing out of unused sick or vacation days due the employee during the leave.
- (c) Catch-up option. Upon prior agreement between the Participant and the Employer, participation may continue during an unpaid leave. When the Participant returns to work, the Participant's benefit deductions will re-calculated and the balance of his or her Health Care Reimbursement Benefit election will be deducted equally among the number of remaining paychecks left in the Plan Year on a pre-tax basis. Alternatively, the benefit deduction amounts that would have been made had the Participant not been on leave will be held in arrears and deducted from the first paycheck the Participant receives after returning to work, on a pre-tax basis. If the Participant does not return to work, the Employer is entitled to recoup those payments for claims made against his or her Health Care Reimbursement Account for expenses incurred while the Participant was on an unpaid leave.

## **ARTICLE IV BENEFITS**

### **4.1 Provision of Benefits.**

Benefits under the Plan shall take the form of reimbursement of Dependent Care Expenses incurred by a Participant or the Participant's Spouse on behalf of a Dependent during the Plan Year. A Participant or former Participant shall be entitled to benefits under the Plan for Dependent Care Expenses incurred only while a Participant.

### **4.2 Amount of Reimbursement.**

A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Dependent Care Reimbursement Benefits. The amount of a Participant's Dependent Care Reimbursement Benefits shall be available during the Plan Year in accordance with the provisions of section 5.2.

### **4.3 Change in Participant Election.**

A Participant may not change the amount of Dependent Care Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively (except for the retroactive enrollment right under Code section 9801 (f) that applies to a timely election made after a birth, adoption, or placement of a child for adoption), and apply only to those benefits accruing to the Participant after the effective date of the new Benefits Enrollment Application.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of this Plan.

### **4.4 Nondiscriminatory Benefits.**

The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

### **4.5 Tax Treatment.**

While it is County's intent that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, the County cannot guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes.

Furthermore, the County will not be liable for any income or other taxes imposed upon an

Employee, Spouse, Dependent, or any other person by reason of any benefits received under the Plan.

**4.6 Maximum Benefits.**

Notwithstanding any other provisions of this Plan, no Participant shall receive Dependent Care Reimbursement Benefits in excess of \$5,000.00 (or \$2,500.00 in the case of a married Participant filing a separate Federal income tax return) in a calendar year.

**ARTICLE V**  
**FUNDING AND PAYMENT OF BENEFITS**

**5.1 Funding.**

The Employer shall contribute amounts necessary to fund the Plan, as determined primarily by the amount of the Dependent Care Reimbursement Benefits to be made available for the Plan Year. Contributions to the Plan for the Plan Year shall include amounts determined by the Salary Reduction Agreements entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

**5.2 Participants' Accounts and Account Balances.**

The Plan Administrator shall establish a separate Dependent Care Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Dependent Care Reimbursement Benefits Account with the amount of Dependent Care Reimbursement Benefits to be made available to the Participant pursuant to the Agreement to Participate and Benefits Enrollment Application as those amounts are actually contributed to the Plan. The Plan Administrator shall charge a Participant's Dependent Care Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The amount of any reimbursement of Dependent Care Expenses may not exceed the balance of the Participant's Dependent Care Reimbursement Account at the time of the reimbursement. The Plan Administrator may also establish a minimum reimbursement amount. Requests submitted below the established minimum reimbursement amount shall not be reimbursed during the Plan Year, including the grace period set forth in section 5.4, except when the reimbursement results in a zero balance.

**5.3 Payment of Benefits.**

Reimbursement shall only be made under the Plan on the basis of Dependent Care Expenses incurred by the Participant or the Participant's Spouse, as presented to the Plan Administrator on a written form specified by the Plan Administrator. It shall be the duty of the Plan Administrator to construe what are and what are not Dependent Care Expenses subject to reimbursement from a Participant's Dependent Care Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Dependent Care Expense, subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Dependent Care Expense within a reasonable time. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

- (a) the name of the person or persons from whom the expenses have been incurred;
- (b) the nature of the expenses incurred;
- (c) the date the expenses were incurred;
- (d) the amount of the requested reimbursement; or,
- (e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Dependent Care Expense

subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

- (a) Executor of the estate of the deceased Participant;
- (b) Spouse or domestic partner;
- (c) Family member held responsible for payment of deceased's medical bills;
- (d) Spouse of Participant with COBRA continuation rights.

#### **5.4 Forfeiture of Benefits.**

If, as of the end of the Plan Year, a Participant has not had the opportunity to incur Dependent Care Expenses equal to the amount in his/her Dependent Care Reimbursement Benefits Account, the Participant shall be given until the March 15 of the immediately following Plan Year in which to incur Dependent Care Expenses to submit for reimbursement against that remaining balance ("grace period"), up to a maximum of \$5,000.00. For any Plan Year, claims for reimbursement of Dependent Care Expenses incurred either during the Plan Year or the grace period must be provided to the Plan Administrator no later than April 15<sup>th</sup> following the end of the Plan Year. Any remaining balance in the Participant's Dependent Care Reimbursement Benefits Account for that Plan Year shall be forfeited. Notwithstanding, Participants who terminate prior to the end of the Plan Year must submit outstanding claims incurred through their last day of employment, no later than the last day of the Plan Year. Upon forfeiture, the Participant's Dependent Care Reimbursement Benefits Account shall be reduced to zero (0). At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

#### **5.5 Dependent Care Credit Under Federal Income Tax.**

Employees will not be permitted to claim a Federal Income tax credit for any Dependent Care Expenses which are reimbursed under the Plan.

#### **5.6 Annual Report to Participants.**

On or before January 31, the Plan Administrator shall provide a written statement to each Participant (or former Participant) of the amount of reimbursements of Dependent Care Expenses paid to the Participant (or former Participant) for the immediately preceding calendar year.

## **ARTICLE VI PLAN ADMINISTRATION**

### **6.1 Plan Administrator.**

The Plan Administrator shall be responsible for the administration of the Plan.

### **6.2 Plan Administrator's Duties.**

In addition to any rights, duties, or powers specified throughout the Plan, the Plan Administrator shall have rights, duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

- (a) to interpret the Plan, to decide all questions of eligibility and participation, to determine the amount, manner, and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;
- (b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;
- (c) to determine the rights of any Participant, Spouse, Dependent, or beneficiary to benefits under the Plan;
- (d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;
- (e) to provide the Employer with such tax or other information it may require in connection with the Plan;
- (f) to employ any agents, attorneys, accountants, or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided such allocation or delegation and the acceptance thereof is in writing;
- (g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure or third-party benefit provider.

Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he or she sees fit to assure that the Plan complies with the nondiscrimination requirements of section 129 of the Code.

### **6.3 Information to be Provided to Plan Administrator.**

The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any Employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his/her correct post office

address, his/her date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator may reasonably request to insure the proper and efficient administration of the Plan.

#### **6.4 Decision of Plan Administrator Final.**

Subject to applicable state of Federal law, and the provisions of section 6.5 below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he or she considers equitable and practicable.

#### **6.5 Review Procedures.**

In cases where the Plan Administrator denies a benefit under this Plan for any Participant or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish, in writing, to said party the reasons for the denial of benefits. The written denial shall be provided to the party within thirty (30) days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary and explain the Plan's claim review procedures. If requested in writing, and within one hundred and eighty (180) days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within sixty (60) days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his/her final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

#### **6.6 Extensions of Time.**

In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any claimant may need to appeal a claim, upon proper application to the Plan Administrator.

#### **6.7 Rules to Apply Uniformly.**

The Plan Administrator shall perform his/her duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

#### **6.8 Indemnity.**

The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who

has been employed, hired, or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

#### 6.4 Decision of Plan Administrator Final.

Subject to applicable state or Federal law, and the provisions of section 6.5 below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he or she considers equitable and practicable.

#### 6.5 Review Procedures.

In cases where the Plan Administrator denies a benefit under this Plan for any Participant or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish, in writing, to said party the reasons for the denial of benefits. The written denial shall be provided to the party within thirty (30) days of the date the benefit was denied by the Plan Administrator. The written denial shall also be provided to any Plan or section of the Plan upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional facts or materials needed to properly complete the claim and explain why such data or material is necessary and explain the Plan's claim review procedure. If requested in writing, and within one hundred and eighty (180) days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within sixty (60) days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his/her final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

#### 6.6 Extensions of Time.

In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any claimant may need to appeal a claim, upon proper application to the Plan Administrator.

#### 6.7 Rules to Apply Uniformly.

The Plan Administrator shall perform his/her duties in a responsible manner and on a non-discriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

#### 6.8 Indemnity.

The Employer does hereby agree to indemnify and hold harmless to the extent allowed by law, and over and above any liability coverage contract, a director and officer of insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who

## ARTICLE VII GENERAL PROVISIONS

### **7.1 Amendment and Termination.**

The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendment apply retroactively to the extent necessary so that the Plan remains in compliance with section 129 of the Code or any other provision of the Code applicable to the Plan.

### **7.2 Nonassignability.**

Any benefits to any Participant under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents, and beneficiaries. No benefit shall voluntarily or involuntarily assigned, sold, or transferred.

### **7.3 Not an Employment Contract.**

By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any Employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

### **7.4 Participant Litigation.**

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their designated representatives shall be the sole source of service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

### **7.5 Addresses, Notice and Waiver of Notice.**

Each Participant shall furnish the Employer with his/her correct post office address. Any communication, statement, or notice addressed to a Participant at his/her last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

### **7.6 Required Information.**

Each Participant shall furnish to the Employer such documents, evidence, or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

### **7.7 Severability.**

In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had

never existed under the Plan.

ARTICLE VII  
GENERAL PROVISIONS

**7.8 Applicable Laws.**

The Plan is governed by the Code and the Regulations issued thereunder (as they might be amended from time to time). 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 of California.

7.2 Nonassignability.  
Any benefits to any Participant under this Plan shall be nonassignable and for the exclusive benefit of Participants. Executed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Employer: COUNTY OF RIVERSIDE

7.3 Not an Employment Contract.  
By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

\_\_\_\_\_  
Chairman, Board of Supervisors

7.4 Participant Litigation.  
In any action or proceeding against the Plan, or the administrator thereof, Employees or former Employees of the Employer or any third person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their designated representatives shall be the sole source of service of process against the Plan. Any final judgment which is not appealed or quashed shall be binding on the Employer and any interested party to the Plan.

7.5 Advance Notice and Waiver of Notice.  
Each Participant shall furnish the Employer with his/her correct home office address. Any communication, statement or notice addressed to a Participant at his/her last post office address as filed with the Employer will be binding on such person. The responsibility of any Administrator shall be under no obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan shall be deemed to have been given to such person entitled to such notice.

FORM APPROVED  
COUNTY COUNSEL

DEC 1 2005

BY [Signature]

7.6 Required Information.  
Each Participant shall furnish to the Employer such designations, powers of appointment, as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.7 Severability.  
If any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any other provision of the Plan, and the Plan shall be construed as if such illegal or invalid provision had not been included.

---

**THE COUNTY OF RIVERSIDE  
HEALTH CARE REIMBURSEMENT PLAN**

---

## TABLE OF CONTENTS

ARTICLE I INTRODUCTION.....	1
1.1 Creation and Title.....	1
1.2 Effective Date.....	1
1.3 Purpose.....	1
ARTICLE II DEFINITIONS.....	2
ARTICLE III PARTICIPATION.....	5
3.1 Eligibility.....	5
3.2 Commencement of Participation.....	5
3.3 Term of Participation.....	5
3.4 Participation by Rehired Employees.....	6
3.5 COBRA Continuation Coverage.....	6
3.6 Family Medical Leave Act.....	6
ARTICLE IV BENEFITS.....	7
4.1 Provision of Benefits.....	7
4.2 Amount of Reimbursement.....	7
4.3 Change in Participant Election.....	7
4.4 Nondiscriminatory Benefits.....	7
4.5 Tax Treatment.....	8
4.6 Maximum Benefits.....	8
ARTICLE V FUNDING AND PAYMENT OF BENEFITS.....	9
5.1 Funding.....	9
5.2 Participants' Accounts.....	9
5.3 Payment of Benefits.....	9
5.4 Forfeiture of Benefits.....	10
5.5 Annual Report to Participants.....	10
ARTICLE VI PLAN ADMINISTRATION.....	11
6.1 Plan Administrator.....	11
6.2 Plan Administrator's Duties.....	11
6.3 Information to be Provided to Plan Administrator.....	11
6.4 Decision of Plan Administrator Final.....	12
6.5 Review Procedures.....	12
6.6 Extensions of Time.....	12
6.7 Rules to Apply Uniformly.....	12
6.8 Indemnity.....	12

ARTICLE VII DISCLOSURE OF PROTECTED HEALTH INFORMATION .....	14
7.1 Definitions.....	14
7.2 Disclosure of Summary Health Information. ....	14
7.3 Employer Certification and Responsibility. ....	15
7.4 Employees With Access to Protected Health Information. ....	15
7.5 Noncompliance.....	16
7.6 Data Security Standards.....	16
ARTICLE VIII GENERAL PROVISIONS .....	17
8.1 Amendment and Termination. ....	17
8.2 Nonassignability.....	17
8.3 Not an Employment Contract. ....	17
8.4 Participant Litigation. ....	17
8.5 Addresses, Notice and Waiver of Notice.....	17
8.6 Required Information. ....	17
8.7 Severability. ....	18
8.8 Applicable Laws.....	18

**ARTICLE I  
INTRODUCTION**

**1.1 Creation and Title.**

The County hereby amends its welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as The County of Riverside Health Care Reimbursement Plan.

**1.2 Effective Date.**

The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2005. The Plan was originally effective January 1, 2000.

**1.3 Purpose.**

The purpose of the Plan is to provide reimbursement for certain medical expenses of the Participants not otherwise covered by insurance or by a health plan sponsored by the County as Employer. The County intends that the Plan qualify as an accident and health plan under section 105(e) of the Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participants' income under section 105(b) of the Code.

## ARTICLE II DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

- 2.1 "Agreement to Participate"** means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Health Care Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.
- 2.2 "Benefits Enrollment Application"** means the completion of paper forms and/or submission of electronic enrollment in which an Eligible Employee selects from the various benefits sponsored by the Employer, including coverage under the Plan. The Benefits Enrollment Application shall set forth the amount of Health Care Reimbursement Benefits to be made available for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.
- 2.3 "Code"** means the Internal Revenue Code of 1986, as amended from time to time.
- 2.4 "Compensation"** means all earned income, salary, wages, and other earnings except bonuses and overtime paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a Salary Reduction Agreement which are not includable in gross income under sections 125, 402(g)(3), 402(h), 403(b), or 457(b) of the Code.
- 2.5 "Dependent"** means an individual who is a dependent within the meaning of section 152(a) of the Code as modified by Code sections 105 and 106 and respective Regulations thereunder, of a Participant in the Plan.
- 2.6 "Effective Date"** of the Plan, as amended and restated, shall be January 1, 2005.
- 2.7 "Eligible Employee"** means an Employee, as defined in section 2.8 below, who has met the eligibility requirements of the Plan set out in section 3.1.
- 2.8 "Employee"** means an individual who is a "regular employee", as defined in Salary Ordinance No. 440 of the County. The term Employee excludes per diem, temporary and seasonal employees, as defined in Salary Ordinance Number 440 of the County, leased employees as defined in Code section 414(n), and each individual whom the County treats as an independent contractor, even if s/he might otherwise satisfy certain of the legal tests or criteria to be considered a common law employee of the County.
- 2.9 "Employer" or "County"** means The County of Riverside, a political subdivision of the State of California, and any of its affiliates, successors, or assignors which adopt the Plan.
- 2.10 "Entry Date"** means for each Eligible Employee, the first day of the month coincident with the day that the Employee becomes eligible to participate in the Plan.

**2.11** **“Health Care Reimbursement Benefits”** means, for any Plan Year, the amount available to a participant as benefits in the form of reimbursements of Qualified Expenses.

**2.12** **“Health Care Reimbursement Benefits Account”** means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid..

**2.13** **“Participant”** means any Employee who has met the eligibility requirements of section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Agreement to Participate and Salary Reduction Agreement and Benefits Enrollment Application.

**2.14** **“Plan”** means The County of Riverside Health Care Reimbursement Plan, as described herein.

**2.15** **“Plan Administrator”** means the Human Resources Director or such other person or committee as may be appointed by the Human Resources Director to administer the Plan.

**2.16** **“Plan Year”** means the twelve (12) consecutive month period beginning on January 1<sup>st</sup> and ending December 31<sup>st</sup>.

**2.17** **“Qualified Expenses”** means the medical expenses incurred during a Plan Year by a Participant, the Participant’s Spouse, or the Participant’s Dependents while the Participant is a Participant, otherwise allowed as a deduction for medical expenses under section 213(d) of the Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

**2.18** **“Regulation”** means any applicable regulation established by the U.S. Treasury that relate to benefit plans established under the Code.

**2.19** **“Salary Reduction Agreement”** means the agreement by an Employee authorizing the Employer to reduce the Employee’s Compensation while a Participant during the Plan Year for purposes of obtaining Health Care Reimbursement Benefits under the Plan.

**2.20** **“Spouse”** means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

**2.21** **“Status Change”** means any of the following with respect to Plan benefits:

- (a) Legal marital status. Events that change an Employee’s legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) Number of Dependents. Events that change an Employee’s number of Dependents, including the following: birth; death; adoption; and placement for adoption.
- (c) Employment status. Any of the following events that change the employment status

of the Employee, Spouse, or a Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer or the employer of a 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 paragraph.

- (d) Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) Residence. A change in the place of residence of the Employee, Spouse or Dependent.
- (f) Judgment, decree, or order. This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in section 609 of ERISA) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code section 152 (except that any child to whom Code section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan; or permit the Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child.
- (g) Entitlement to Medicare or Medicaid. If an Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Employee to make a prospective election change to cancel or reduce coverage of that Employee or Dependent under the Plan. In addition, if an Employee, Spouse or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Employee to make a prospective election to commence or increase coverage of that Employee, Spouse or Dependent under the Plan.
- (h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code section 125.

### **3.4 Participation by Rehired Employees.**

If a terminated Employee is rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may elect to resume participation in the Plan under the terms of the Salary Reduction Agreement and Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year.

### **3.5 COBRA Continuation Coverage.**

Subject to any provision in the Code or Regulations governing COBRA Continuation Coverage to the contrary, COBRA type continuation shall be available to Participants to the extent required by law. Notwithstanding any other provisions in this Article III, any Participant, Spouse, or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse, or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under section 4980B of the Code or applicable state law, as may be required from time to time and shall advise affected individuals of the terms and conditions of such continuation coverage.

### **3.6 Family Medical Leave Act.**

Subject to any provision in the Code or Regulations governing Family Medical Leave Act (FMLA) coverage to the contrary, FMLA-type continuation coverage shall be available to all qualifying Participants.

If the leave is paid, contributions may continue to be made under the Plan as elected under Section 3.2. Payment options for coverage while on unpaid leave include the following:

- (a) Pre-pay before commencement of leave through pre-tax Salary Reduction Agreement from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met.
- (b) Pay as you go option. Participants may pay their share of Health Care Reimbursement Benefits on an after-tax basis on the same schedule as payments would be made if the employee were not on leave, or on a pre-tax basis to the extent that the contributions are made from taxable compensation, including cashing out of unused sick or vacation days due the employee during the leave.
- (c) Catch-up option. Upon prior agreement between the Participant and the Employer, participation may continue during an unpaid leave. When the Participant returns to work, the Participant's benefit deductions will re-calculated and the balance of his or her Health Care Reimbursement Benefit election will be deducted equally among the number of remaining paychecks left in the Plan Year on a pre-tax basis. Alternatively, the benefit deduction amounts that would have been made had the Participant not been on leave will be held in arrears and deducted from the first paycheck the Participant receives after returning to work, on a pre-tax basis. If the Participant does not return to work, the Employer is entitled to recoup those payments for claims made against his or her Health Care Reimbursement Account for expenses incurred while the Participant was on an unpaid leave.

## **ARTICLE III PARTICIPATION**

### **3.1 Eligibility.**

Each Employee, as defined in section 2.8 above, shall be eligible to participate in the Plan if:

- (a) the Employee is eligible to participate in the County of Riverside Flexible Benefit Program; and
- (b) if the Employee is represented for collective bargaining purposes by an association or union, that association or union adopts this Plan through a memorandum of understanding with the County

### **3.2 Commencement of Participation.**

An Eligible Employee shall become a Participant in the Plan after completing the Plan Administrator's executed Benefits Enrollment Application setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year or, with respect to an Employee's initial election period, the remaining portion of the Plan Year that contains the Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan.

A Participant may not modify his Benefits elections at any time during the Plan Year except as provided under Section 4.3. If a Participant wants to change his elections for a forthcoming Plan Year, the Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Application, which may be completed in paper or electronic form. Each new Benefits Enrollment Application shall specify the type and amount of Benefits to be made available to the Participant for the immediately following Plan Year. A Participant who fails to execute a valid Benefits Enrollment Application for any Plan Year before the start of the Plan Year with respect to participation in the County's Health Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

### **3.3 Term of Participation.**

Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

- (a) the date the Participant dies, resigns, or terminates employment with the Employer, subject to the provisions of section 3.4;
- (b) the date the Participant fails to make the required contributions under the Plan;
- (c) the date the Participant ceases to be an Employee; or,
- (d) the date the Plan terminates.

A Participant's Health Care Reimbursement Benefits Account will remain open for the remainder of the Plan Year in which termination occurs, but ONLY for reimbursement of Qualified Expenses incurred prior to the Participant's termination date unless the Participant elects to continue coverage as defined in section 3.5 below.

## **ARTICLE IV BENEFITS**

### **4.1 Provision of Benefits.**

Benefits under the Plan shall take the form of reimbursement of Qualified Expenses incurred by a Participant, the Participant's Spouse, and the Participant's Dependents during the Plan Year. A Participant, or former Participant shall be entitled to benefits under the Plan for Qualified Expenses incurred only while a Participant, unless continuation coverage is elected pursuant to section 3.5.

### **4.2 Amount of Reimbursement.**

A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Health Care Reimbursement Benefits. The amount of a Participant's Health Care Reimbursement Benefits shall be uniformly available during the Plan Year.

### **4.3 Change in Participant Election.**

A Participant may not change the amount of Health Care Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively (except for the retroactive enrollment right under Code section 9801 (f) that applies to a timely election made after a birth, adoption, or placement of a child for adoption), and apply only to those benefits accruing to the Participant after the effective date of the new Benefits Enrollment Application.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment period. With respect to any other change in election, the Plan Administrator shall determine if the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of this Plan, except as provided for in section 5.4.

### **4.4 Nondiscriminatory Benefits.**

The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated Employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

**4.5 Tax Treatment.**

While it is County's intent that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, the County cannot guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes.

Furthermore, the County will not be liable for any income or other taxes imposed upon an Employee, Spouse, Dependent, or any other person by reason of any benefits received under the Plan.

**4.6 Maximum Benefits.**

Notwithstanding any other provisions of this Plan, no Participant shall receive Health Care Reimbursement Benefits in excess of \$15,000.00 per Plan Year.

**4.3 Change in Participant Election.**

A Participant may not change the amount of Health Care Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively (except for the retroactive enrollment right under Code section 9901(f) that applies to a timely election made after a birth, adoption or placement of a child for adoption), and apply only to those benefits accruing to the Participant after the effective date of the new Benefits Enrollment Application.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment period. With respect to any other change in election, the Plan Administrator shall determine if the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of the Plan, except as provided for in section 5.4.

**4.4 Nondiscrimination Benefits.**

The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated Employees from participation in the Plan if the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

**ARTICLE V**  
**FUNDING AND PAYMENT OF BENEFITS**

**5.1 Funding.**

The Employer shall contribute amounts necessary to fund the Plan, as determined primarily by the amount of the Health Care Reimbursement Benefits to be made available for the Plan Year. Contributions to the Plan for the Plan Year shall include amounts determined by the Salary Reduction Agreements entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

**5.2 Participants' Accounts.**

The Plan Administrator shall establish a separate Health Care Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Health Care Reimbursement Benefits Account with the amount of Health Care Reimbursement Benefits to be made available to the Participant pursuant to the Agreement to Participate and Benefits Enrollment Application. The Plan Administrator shall charge a Participant's Health Care Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The Plan Administrator may also establish a minimum reimbursement amount. Requests submitted below the established minimum reimbursement amount shall not be reimbursed during the Plan Year, including the grace period set forth in section 5.4, except when the reimbursement results in a zero balance.

**5.3 Payment of Benefits.**

Reimbursement shall only be made under the Plan on the basis of Qualified Expenses incurred by the Participant, the Participant's Spouse, or the Participant's Dependents, as presented to the Plan Administrator on a written form specified by the Plan Administrator and as evidenced by a written statement from a third party. It shall be the duty of the Plan Administrator to construe what are and what are not Qualified Expenses subject to reimbursement from a Participant's Health Care Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Qualified Expense, subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Qualified Expense within a reasonable time. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

- (a) the name of the person or persons from whom the expenses have been incurred;
- (b) the nature of the expenses incurred;
- (c) the date the expenses were incurred;
- (d) the amount of the requested reimbursement; or,
- (e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Qualified Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be

made in the following priority:

- (a) Executor of the estate of the deceased Participant;
- (b) Spouse/ domestic partner;
- (c) Family member held responsible for payment of deceased's medical bills;
- (d) Spouse of Participant with COBRA continuation rights.

**5.4 Forfeiture of Benefits.**

If, as of the end of the Plan Year, a Participant has not had the opportunity to incur Qualified Expenses equal to the amount in his/her Health Care Reimbursement Benefits Account, the Participant shall be given until the March 15 of the immediately following Plan Year in which to incur Qualified Expenses to submit for reimbursement against that remaining balance ("grace period"), up to a maximum of \$5,000.00. For any Plan Year, claims for reimbursement of Qualified Expenses incurred either during the Plan Year or the grace period must be provided to the Plan Administrator no later than April 15<sup>th</sup> following the end of the Plan Year. Any remaining balance in the Participant's Health Care Reimbursement Benefits Account for that Plan Year shall be forfeited. Notwithstanding, Participants who terminate prior to the end of the Plan Year must submit outstanding claims incurred through their last day of employment, no later than the last day of the Plan Year. Upon forfeiture, the Participant's Health Care Reimbursement Benefits Account shall be reduced to zero (0). At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

**5.5 Annual Report to Participants.**

On or before January 31, the Plan Administrator shall provide a written statement to each Participant (or former Participant) of the amount of reimbursements of Qualifying Expenses paid to the Participant (or former Participant) for the immediately preceding calendar year.

**ARTICLE VI**  
**PLAN ADMINISTRATION**

**6.1 Plan Administrator.**

The Plan Administrator shall be responsible for the administration of the Plan.

**6.2 Plan Administrator's Duties.**

In addition to any rights, duties, or powers specified throughout the Plan, the Plan Administrator shall have such rights, duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

- (a) to interpret the Plan, to decide all questions of eligibility and participation, to determine the amount, manner, and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;
- (b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;
- (c) to determine the rights of any Participant, Spouse, Dependent, or beneficiary to benefits under the Plan;
- (d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;
- (e) to provide the Employer with such tax or other information it may require in connection with the Plan;
- (f) to employ any agents, attorneys, accountants, or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided such allocation or delegation and the acceptance thereof is in writing;
- (g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure or third-party benefit provider.

Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he or she sees fit to assure that the Plan complies with the nondiscrimination requirements of section 105 of the Code.

**6.3 Information to be Provided to Plan Administrator.**

The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any Employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant, Spouse or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his/her correct post office

address, his/her date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator may reasonably request to insure the proper and efficient administration of the Plan.

#### **6.4 Decision of Plan Administrator Final.**

Subject to applicable state or Federal law, and the provisions of section 6.5 below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he or she considers equitable and practicable.

#### **6.5 Review Procedures.**

In cases where the Plan Administrator denies a benefit under this Plan for any Participant or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish, in writing, to said party the reasons for the denial of benefits. The written denial shall be provided to the party within thirty (30) days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within one hundred and eighty (180) days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within sixty (60) days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his/her final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

#### **6.6 Extensions of Time.**

In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any claimant may need to appeal a claim, upon proper application to the Plan Administrator.

#### **6.7 Rules to Apply Uniformly.**

The Plan Administrator shall perform his/her duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

#### **6.8 Indemnity.**

The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who has been

employed, hired, or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

1.1 Definitions

- Whenever used in this Article VII, the following terms shall have the meaning ascribed to them below:
- (a) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
  - (b) Health Information - means information (whether oral or written in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR §160.103), employer, the insurer, school or university, or health care clearinghouse (as defined in 45 CFR §160.103) 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.
  - (c) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
  - (d) Summary Health Information - means information that summarizes the claim history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed:
    - (1) Names;
    - (2) Geographic information more specific than state;
    - (3) All elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 65 and all elements of dates, including the year, indicative of a birth age (except for ages and elements may be aggregated into a single category of age 60 and older);
    - (4) Other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
    - (5) Facial photographs or biometric identifiers (e.g., fingerprint) and
    - (6) Any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
  - (e) Protected Health Information ("PHI") - means individually identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

1.2 Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modeling, underwriting, or terminating the Plan.

**ARTICLE VII**  
**DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**7.1 Definitions.**

Whenever used in this Article VII, the following terms shall have the respective meanings set forth below.

- (a) Plan Administration Functions—means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
- (b) Health Information—means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR §160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR §160.103) 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.
- (c) Individually Identifiable Health Information—means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
- (d) Summary Health Information—means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed:
  - (1) Names;
  - (2) Geographic information more specific than state;
  - (3) All elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
  - (4) Other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
  - (5) Facial photographs or biometric identifiers (e.g., finger prints); and
  - (6) Any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
- (e) Protected Health Information ("PHI")—means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

**7.2 Disclosure of Summary Health Information.**

The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

The Plan will disclose PHI to the Employer only in accordance with 45 CFR §164.504(f) and the provisions of this Article VII.

PHI disclosed to the Employer in accordance with this Article may only be used for the following permitted and required uses and disclosures:

- (a) Claims Processing
- (b) Plan Auditing
- (c) Quality Assurance

### **7.3 Employer Certification and Responsibility.**

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended.

Additionally, the Employer agrees:

- (a) not to use or further disclose PHI other than as permitted in section 7.4 or as required by law;
- (b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
- (c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
- (d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in section 7.4;
- (e) to make PHI available to individuals in accordance with 45 CFR §164.524;
- (f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR §164.526;
- (g) to make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR §164.528;
- (h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and
- (i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
- (j) to ensure that adequate separation between the Plan and the Employer, as required by 45 CFR §164.504(f), is established and maintained.

### **7.4 Employees With Access to Protected Health Information.**

The Plan will disclose PHI only to the following employees or classes of employees:

- (a) The Human Resources Department, which has been designated the HIPAA Privacy and Compliance Office of the County;
- (b) The County Information Security Officer;

- (c) Any other individual who is under the control of the Employer and who receives PHI relating to the Plan in the ordinary course of business (within the meaning of 45 CFR § 164.504(f)(2)(iii)) and who has been designated, in writing, by the County's HIPAA Privacy and Compliance Office.

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

#### **7.5 Noncompliance.**

Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Article by individuals described in section 7.4 shall be addressed in compliance with the Health Privacy and Security Policy most recently adopted by the County Board of Supervisors.

#### **7.6 Data Security Standards.**

Effective April 21, 2005, the Employer, as plan sponsor, shall:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (b) Ensure that the adequate separation required by 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (d) Report to the Plan any security incident of which it becomes aware.

All terms used but not otherwise defined in the Plan shall have the same meaning as those terms in 45 CFR Parts 160 and 164.

**ARTICLE VIII  
GENERAL PROVISIONS**

**8.1 Amendment and Termination.**

The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendment apply retroactively to the extent necessary so that the Plan remains in compliance with section 105 of the Code or any other provision of the Code applicable to the Plan.

**8.2 Nonassignability.**

Any benefits to any Participant under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents, and beneficiaries. No benefit shall voluntarily or involuntarily assigned, sold, or transferred.

**8.3 Not an Employment Contract.**

By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any Employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

**8.4 Participant Litigation.**

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their designated representatives shall be the sole source of service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

**8.5 Addresses, Notice and Waiver of Notice.**

Each Participant shall furnish the Employer with his/her correct post office address. Any communication, statement, or notice addressed to a Participant at his/her last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

**8.6 Required Information.**

Each Participant shall furnish to the Employer such documents, evidence, or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

**8.7 Severability.**

In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

**8.8 Applicable Laws.**

The Plan is governed by the Code and the Regulations issued thereunder (as they might be amended from time to time). 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 of California.

Executed this \_\_\_\_\_ day of \_\_\_\_\_,

Employer: COUNTY OF RIVERSIDE

Chairman, Board of Supervisors

FORM APPROVED  
COUNTY COUNSEL

DEC 1 2005

BY [Signature]

Internal Revenue Bulletin: 2005-23  
June 6, 2005

Notice 2005-42

***Modification of Application of Rule Prohibiting Deferred Compensation Under a Cafeteria Plan***

---

**Table of Contents**

- PURPOSE
- BACKGROUND
- MODIFICATION OF APPLICATION OF RULE PROHIBITING DEFERRED COMPENSATION UNDER A § 125 CAFETERIA PLAN
- EFFECT ON OTHER DOCUMENTS
- DRAFTING INFORMATION

**PURPOSE**

The purpose of this notice is to modify the application of the rule prohibiting deferred compensation under a § 125 cafeteria plan. This notice permits a grace period immediately following the end of each plan year during which unused benefits or contributions remaining at the end of the plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during the grace period.

**BACKGROUND**

In general, no amount is included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan. Section 125(a). A cafeteria plan is defined in § 125(d)(1) as a written plan maintained by an employer under which all participants are employees, and the participants may choose among two or more benefits consisting of cash and qualified benefits. Section 125(f) defines a "qualified benefit" as any benefit which, with the application of § 125(a), is not includable in the gross income of the employee by reason of an express provision of Chapter I of the Internal Revenue Code (other than §§ 106(b), 117, 127 or 132). Qualified benefits include employer-provided accident and health plans excludable from gross income under §§ 106 and 105(b), group-term life insurance excludable under § 79, dependent care assistance programs excludable under § 129 and adoption assistance programs excludable under § 137. Elections under a cafeteria plan, once made, can be changed or revoked only as provided in Treas. Reg. § 1.125-4. A cafeteria plan must have a plan year specified in the written plan document. Prop. Treas. Reg. § 1.125-1, Q&A-3.

Section 125(d)(2)(A) states that the term "cafeteria plan" does not include any plan which provides for deferred compensation. The statutory prohibition on deferred compensation in a cafeteria plan is addressed in Prop. Treas. Reg. §§ 1.125-1 and 1.125-2. Prop. Treas. Reg. § 1.125-2, Q&A-5 states that:

A cafeteria plan may not include any plan that offers a benefit that defers the receipt of compensation. In addition, a cafeteria plan may not operate in a manner that enables employees to defer compensation. For example, a plan that permits employees to carry over unused elective contributions or plan benefits (e.g., accident or health plan coverage) from one plan year to another operates to defer compensation. This is the case regardless of how the contributions or benefits are used by the employee in the subsequent plan year (e.g., whether they are automatically or electively converted into another taxable or nontaxable benefit in the subsequent plan year or used to provide additional benefits of the same type). Similarly, a cafeteria plan operates to permit the deferral of compensation if the plan permits participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year ... .

See also Prop. Treas. Reg. § 1.125-1, Q&A-7.

Thus, a cafeteria plan does not include any plan that defers the receipt of compensation or operates in a manner that enables participants to defer compensation by, for example, permitting participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year. This rule is commonly referred to as the "use-it-or-lose-it" rule, requiring that unused contributions or benefits remaining at the end of the plan year be "forfeited."

However, other areas of tax law provide that for a short, limited period, compensation for services paid in the year following the year in which the services that are being compensated were performed is not treated as "deferred compensation." For example, Treas. Reg. § 1.404(b)-1T, Q&A-2(a) provides that for purposes of the deduction rules in § 404(a), (b) and (d), a plan, or method or arrangement defers the receipt of compensation or benefits to the extent it is one under which an employee receives compensation or benefits more than a brief period of time after the end of the employer's taxable year in which the services creating the right to such compensation or benefits are performed. Under Treas. Reg. § 1.404(b)-1T, Q&A-2(c), a plan, or method or arrangement shall not be considered as deferring the receipt of compensation or benefits for more than a brief period of time after the end of the employer's taxable year to the extent that compensation or benefits are received by the employee on or before the fifteenth day of the third calendar month after the end of the employer's taxable year in which the services are rendered. See also *Weaver v. Commissioner*, 121 T.C. 273 (2003); Rev. Rul. 88-68, 1988-2 C.B. 117. Cf. H. R. Conf. Rep. No. 755, 108<sup>th</sup> Cong., 2d Sess. at 735 (2004) (§ 409A "does not apply to annual bonuses or other annual compensation amounts paid within 2 and 1/2 months after the close of the taxable year in which the relevant services required for payment have been performed"). Consistent with these other areas of tax law, Treasury and the IRS believe it is appropriate to modify the current prohibition on deferred compensation in the proposed regulations under § 125 to permit a grace period after the end of the plan year during which unused benefits or contributions may be used.

#### **MODIFICATION OF APPLICATION OF RULE PROHIBITING DEFERRED COMPENSATION UNDER A § 125 CAFETERIA PLAN**

The rule that a cafeteria plan may not defer the receipt of compensation as set out in Prop. Treas. Reg. §§ 1.125-1 and 1.125-2 is modified as follows: A cafeteria plan document may, at the employer's option, be amended to provide for a grace period immediately following the end of each plan year. The grace period must apply to all participants in the cafeteria plan. Expenses for qualified benefits incurred during the grace period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding plan year. The grace period must not extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding plan year to which it relates (*i.e.*, "the 2 and 1/2 month rule"). If a cafeteria plan document is amended to include a grace period, a participant who has unused benefits or contributions relating to a particular qualified benefit from the immediately preceding plan year, and who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. The effect of the grace period is that the participant may have as long as 14 months and 15 days (the 12 months in the current cafeteria plan year plus the grace period) to use the benefits or contributions for a plan year before those amounts are "forfeited" under the "use-it-or-lose-it" rule.

During the grace period, a cafeteria plan may not permit unused benefits or contributions to be cashed-out or converted to any other taxable or nontaxable benefit. Unused benefits or contributions relating to a particular qualified benefit may only be used to pay or reimburse expenses incurred with respect to that particular qualified benefit. For example, unused amounts elected to pay or reimburse medical expenses in a health flexible spending arrangement (FSA) may not be used to pay or reimburse dependent care or other expenses incurred during the grace period. To the extent any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the grace period, those remaining unused benefits or contributions may not be carried forward to any subsequent period (including any subsequent plan year) and are "forfeited" under the "use-it-or-lose-it" rule. As under current practice, employers may continue to provide a "run-out" period after the end of the grace period, during which expenses for qualified benefits incurred during the cafeteria plan year and the grace period may be paid or reimbursed.

An employer may adopt a grace period as authorized in this notice for the current cafeteria plan year (and subsequent cafeteria plan years) by amending the cafeteria plan document before the end of the current plan year.

The rules of this notice are illustrated by the following examples:

*Example (1).* Employer with a cafeteria plan year ending on December 31, 2005, amended the plan document before the end of the plan year to permit a grace period which allows all participants to apply unused benefits or contributions remaining at the end of the plan year to qualified benefits incurred during the grace period immediately following that plan year. The grace period adopted by the employer ends on the fifteenth day of the third calendar month after the end of the plan year (March 15, 2006, for the plan year ending December 31, 2005). Employee X timely elected salary reduction of \$1,000 for a health FSA for the plan year ending December 31, 2005. As of December 31, 2005, X has \$200 remaining unused in his health FSA. X timely elected salary reduction for a health FSA of \$1,500 for the plan year ending December 31, 2006. During the grace period from January 1 through March 15, 2006, X incurs \$300 of unreimbursed medical expenses (as defined in § 213(d)). The unused \$200 from the plan year ending December 31, 2005, is applied to pay or reimburse \$200 of X's \$300 of medical expenses incurred during the grace period. Therefore, as of March 16, 2006, X has no unused benefits or contributions remaining for the plan year ending December 31, 2005. The remaining \$100 of medical expenses incurred between January 1 and March 15, 2006, is paid or reimbursed from X's health FSA for the plan year ending December 31, 2006. As of March 16, 2006, X has \$1,400 remaining in the health FSA for the plan year ending December 31, 2006.

*Example (2).* Same facts as Example (1), except that X incurs \$150 of § 213(d) medical expenses during the grace period (January 1 through March 15, 2006). As of March 16, 2006, X has \$50 of unused benefits or contributions remaining for the plan year ending December 31, 2005. The unused \$50 cannot be cashed-out, converted to any other taxable or nontaxable benefit, or used in any other plan year (including the plan year ending December 31, 2006). The unused \$50 is subject to the "use-it-or-lose-it" rule and is "forfeited." As of March 16, 2006, X has the entire \$1,500 elected in the health FSA for the plan year ending December 31, 2006.

### EFFECT ON OTHER DOCUMENTS

Future guidance will modify Prop. Treas. Reg. §§ 1.125-1 and 1.125-2 to reflect the provisions in this notice.

### DRAFTING INFORMATION

The principal author of this notice is Elizabeth Purcell of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Purcell at (202) 622-6080 (not a toll-free call).