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

ITEM: 3.21
(ID # 13904)
MEETING DATE:
Tuesday, December 15, 2020

FROM: HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Ratify and Approve Amendment No. 1 to the County of Riverside Flexible Benefit Program, effective from 1/01/2020, and Approve the County of Riverside Flexible Benefit Program, as Amended and Restated effective 1/01/2021, for Eligible County Employees, All Districts. [Total Cost - $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and Approve Amendment No. 1 to the County of Riverside Flexible Benefit Program, effective from January 1, 2020 (Attachment A); and
2. Approve the County of Riverside Flexible Benefit Program (Attachment B), including its Schedule A – Health Care Reimbursement Plan (Attachment C), and Schedule B – Dependent Care Reimbursement Plan (Attachment D), as amended and restated effective January 1, 2021; and
3. Authorize the Chairman of the Board to sign three (3) copies of the documents on behalf of the County; and
4. Direct the Clerk of the Board to retain one (1) copy of the signed document and return (2) copies of the signed documents to Human Resources for distribution.

ACTION: Policy

Brenda Diederichs, Assistant CEO / Human Resources Director 12/7/2020

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Spiegel, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	December 15, 2020
xc:	H.R.

Kecia R. Harper
Clerk of the Board
By: _____
Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			Budget Adjustment: No	
			For Fiscal Year: 20/21	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:
Summary

The Flexible Benefits Program was first adopted as of November 20, 1986 to allow employees to select among various non-taxable benefits and cash compensation. The County offers a Flexible Spending Account Program which allows eligible employees to enroll in Internal Revenue Code Section 125 pre-tax Health Care Reimbursement and Dependent Care Reimbursement plans. The establishment of the Flexible Spending Account Program was approved by the Board on August 10, 1999, Item 3.62. Administrative services for the Health Care Reimbursement and Dependent Care Reimbursement plans are presently provided by Application Software, Inc. (ASI), pursuant to the administrative services contract originally approved by the Board on September 28, 2010, Item 3.52. The County, through the Human Resources Director, is the Plan Administrator.

The Health Care Reimbursement Plan option reimburses eligible participants on a pre-tax basis for out-of-pocket medical expenses incurred during the plan year that are not covered by insurance or a health plan. The Dependent Care Reimbursement Plan option is used to reimburse eligible participants for child day care expenses, or care of an adult dependent who is incapable of self-care and is claimed as a taxable dependent. For eligible participants who participate in the Health Care Reimbursement and/or Dependent Care Reimbursement plans, they do not pay taxes on the monies that are elected annually and deducted on a bi-weekly basis.

The Internal Revenue Service (IRS) recently issued guidance that provides increased flexibility for Health Care Reimbursement Plan and Dependent Care Reimbursement Plan participants to make mid-year changes in the 2020 plan year due to the COVID-19 pandemic. Employees are eligible to cancel, enroll, increase or decrease their election amounts in the 2020 plan year. Per IRS guidelines, a decrease in contributions cannot be less than the amount of contribution already received in reimbursement from the plan, and refunds of plan contributions are not permitted.

IRS Notice 2020-29 allows until the end of 2021 for the plan to formally adopt the amendments permitting employees to make these changes. Amendment No. 1 to the County of Riverside Flexible Benefit Program will formally adopt these changes effective January 1, 2020.

Prev. Agn. Ref.: 08/10/1999, Item 3.62

Impact on Residents and Businesses

There is no direct impact to residents or private businesses in the County of Riverside.

SUPPLEMENTAL:

Contract History

The Human Resources Department is seeking Board approval to ratify and approve Amendment No. 1 to the County of Riverside Flexible Benefit Program, effective from January 1, 2020, and approve the County of Riverside Flexible Benefit Program, amended and restated effective January 1, 2021.

ATTACHMENTS

ATTACHMENT A. Amendment No. 1 to the County of Riverside Flexible Benefit Program (Effective from January 1, 2020)

ATTACHMENT B. The County of Riverside Flexible Benefit Program (Amended and Restated Effective January 1, 2021)

ATTACHMENT C. Schedule A – Health Care Reimbursement Plan (Amended and Restated Effective January 1, 2021)

ATTACHMENT D. Schedule B – Dependent Care Reimbursement Plan (Amended and Restated Effective January 1, 2021)

Douglas Gardonez Jr. 12/7/2020

Gregory P. Priamos, Director County Counsel 12/3/2020

AMENDMENT NO 1. TO THE
COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

This Amendment is adopted the 15TH day of December, 2020.

WHEREAS, the County of Riverside ("County") maintains The County of Riverside Flexible Benefit Program, as amended and restated effective January 1, 2020 ("Plan"), which incorporates The County of Riverside Health Care Reimbursement Plan ("Health Care Reimbursement Plan") and The County of Riverside Dependent Care Reimbursement Plan ("Dependent Care Reimbursement Plan");

WHEREAS, Section 1.3 of the Plan provides that the purpose of the Plan document is to allow Eligible Employees to select among Compensation and coverage under one or more Benefits, and for such Benefits to be eligible for exclusion from federal income tax;

WHEREAS, pursuant to Section 7.1 of the Plan, the County has the authority to amend the Plan at any time, provided that no amendment shall change the terms and conditions of payment of any Benefit that a Participant, Spouse, Dependent, or designated beneficiary was or might have been entitled to under the Plan prior to the amendment;

WHEREAS, for reasons related to the public health emergency involving COVID-19 and the guidance provided by the Internal Revenue Services in Notice 2020-29, it is appropriate and necessary to amend the Plan to extend the definition of "Grace Period" for the 2019 Plan Year until December 31, 2020 for the Health Care Reimbursement Plan and Dependent Care Reimbursement Plan; and

WHEREAS, for reasons related to the public health emergency involving COVID-19 and the guidance provided by the Internal Revenue Services in Notice 2020-29, it is appropriate and necessary to amend the Plan to permit a "mid-year" enrollment period for the 2020 Plan Year for Eligible Employees and Participants through October 31, 2020 under the Health Care Reimbursement Plan and Dependent Care Reimbursement Plan.

NOW THEREFORE, the Plan is hereby amended as set forth below:

1. Effective January 1, 2020, Section 2.1 of Schedule A to the Plan documents (the "Health Care Reimbursement Plan") is amended to revise the definition of "Grace Period" as follows:

   2.1 "Grace Period" means the provisions that allows a Participant to use amounts remaining from the Plan Year for expenses incurred during an additional 2.5 month period immediately following the Plan Year (i.e., January 1 through March 15 of the following Plan Year), in accordance with IRS Notice 2013-71.

   For reasons related to the public health emergency involving COVID-19 and in accordance with IRS Notice 2020-29, the Grace Period applicable to the 2019 Plan Year extends to December 31, 2020. A Participant may use amounts remaining from the 2019 Plan Year until December 31, 2020.

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DEC 15 2020 3.21

2. Effective August 1, 2020, Section 4.3 of the Plan documents is amended to add a paragraph at the end of the Section to provide for a "mid-year" enrollment period as follows:

4.3 Change in Participant's/Eligible Employee's Benefits Enrollment.

...

Notwithstanding the foregoing, for reasons related to the public health emergency involving COVID-19, an Eligible Employee who elected not to participate in the Plan for the 2020 Plan Year shall be permitted to elect participation in the Plan with respect to coverage under the Health Care Reimbursement Plan and Dependent Care Reimbursement Plan during a "mid-year" enrollment period. Participants who elected participation in the Plan with respect to coverage under the Health Care Reimbursement Plan and Dependent Care Reimbursement Plan shall be permitted to increase, decrease, or revoke their existing election for the 2020 Plan Year without having to experience a Status Change or special enrollment right as outlined above. This one-time "mid-year" enrollment period election is permitted for any reason, but the Participant or Eligible Employee must provide a new Benefits Enrollment Application no later than October 31, 2020. The new Benefits Enrollment Application shall be effective prospectively and shall apply only to those Benefits accruing to the Participant, Spouse, or Dependents after the effective date of the new Benefits Enrollment Application. A Participant may not elect to reduce or revoke an existing election to an amount lower than the amount that has already been reimbursed to the Participant for the 2020 Plan Year.

THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

Amended and Restated Effective January 1, 2021

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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"), previously established and has maintained The County of Riverside Flexible Benefit Program (the "Plan"). The County hereby amends the Plan under the terms and conditions set forth in this document. The Plan incorporates The County of Riverside Health Care Reimbursement Plan (the "Health Care Reimbursement Plan") (attached as Schedule A) and The County of Riverside Dependent Care Reimbursement Plan (the "Dependent Care Reimbursement Plan") (attached as Schedule B).

1.2 Effective Date.
The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2021. The Plan was originally effective November 20, 1986.

1.3 Purpose.
The purpose of the Plan is to allow Eligible Employees to select among Compensation and coverage under one or more Benefits maintained by the County. The County intends that the Plan qualify as a cafeteria plan under Code Section 125 and that the Benefits provided under the Plan be eligible for exclusion from federal income tax. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Code Section 125, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Section 125.

The provisions of The County of Riverside Health Care Reimbursement Plan are intended to qualify as a self-insured medical expense reimbursement program that provides benefits described by Code Sections 105 and 106, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Sections 105 and 106. The health care reimbursement benefits reimbursed under such Health Care Reimbursement Plan are intended to be eligible for exclusion from participating Employees' income under Code Section 105(b).

The provisions of The County of Riverside Dependent Care Reimbursement Plan are intended to qualify as a "dependent care assistance program" under the provisions of Code Section 129, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Section 129. The dependent care reimbursement benefits reimbursed under such Dependent Care Reimbursement Plan are intended to be eligible for exclusion from participating Employees' income under Code Section 129(a).

The provisions of the Plan, as reflected in this document, are applicable only to Eligible Employees who are in the active employ of the County on or after January 1, 2021.

1.4 Compliance with the Code and Other Applicable Laws.

It is intended that the Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

The Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan components of the Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health Care Reimbursement Plan component of the Plan is subject to HIPAA and COBRA; whereas, the Dependent Care Reimbursement Plan is not. The Plan shall be designated as a hybrid entity for purposes of HIPAA, and the Cafeteria Plan shall be a covered entity only with respect to the Health Care Reimbursement Plan.

In addition, the Plan will comply with the requirements of all other applicable law.

ARTICLE II
DEFINITIONS

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

2.1 "Benefit" means one of the various qualified benefits under Code Section 125(f) sponsored by the County and made available by the County through the Plan, including but not limited to medical plans (including prescription drug components), dental plans, vision plans, and health care and dependent care reimbursement benefits.

2.2 "Benefits Account" means one of 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 elections 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, and all applicable regulations and guidance thereunder.

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

2.6 "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.

2.7 "Dependent" means an individual who is a dependent within the meaning of Code Section 152(a) and modified by Code Sections 105 and 106 by an Employee. Notwithstanding the previous sentence, with respect to dependent care reimbursement Benefits, "Dependent" shall have the meaning as set forth in the Dependent Care Reimbursement Plan.

2.8 "Eligible Employee" means an Employee, as defined 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 County in a regular position, 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 No. 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.

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

2.11 "Participant" means any Eligible Employee who has elected to participate in the Plan by providing the Plan Administrator with an executed Salary Reduction Agreement and Benefits Enrollment Application.

2.12 "PHSA" means the Public Health Service Act of 1996, as amended from time to time, or superseded by laws of similar effect, and all applicable regulations and guidance thereunder.

2.13 "Plan" means The County of Riverside Flexible Benefit Program, as described herein, including the incorporated The County of Riverside Health Care Reimbursement Plan (attached as Schedule A) and The Country of Riverside Dependent Care Reimbursement Plan (attached as Schedule B).

2.14 "Plan Administrator" means the Human Resources Director of the County, or such other person or committee as may be appointed by the County 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 "Salary Reduction Agreement" means the agreement by an Eligible Employee authorizing the County to reduce the Eligible Employee's Compensation on a pre-tax basis 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 County in a Plan Year for use in purchasing Benefits available under the Plan.

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

2.19 "Status Change" means any of the following with respect to Benefits under the Plan. A change in election as a result of a Status Change must on account of and consistent with the Status Change, as permitted and pursuant to Code Section 125. The Plan Administrator shall have the authority to determine whether a requested change in election is on account of and consistent with a Status Change.

The following Status Changes apply to medical, dental, vision, health care reimbursement, and dependent care reimbursement benefits:

(a) **Legal marital status.** Events that change an Eligible 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 Eligible 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 Eligible 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 County 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 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 Eligible Employee, Spouse, or Dependent.

The following Status Changes apply only to medical, dental, vision, and health care reimbursement benefits:

(a) **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 the Employee Retirement Income Security Act of 1974, as amended) that requires accident or health coverage for the Eligible Employee's child or for a foster child who is a Dependent of the Eligible Employee (except that any child to whom Code Section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Eligible Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan or permit the Eligible 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.

(b) **Entitlement to Medicare or Medicaid.** If an Eligible 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 Eligible Employee to make a prospective election change to cancel or reduce coverage of that Eligible Employee, Spouse, or Dependent under the Plan. In addition, if an Eligible 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 Eligible Employee to make a prospective election to commence or increase coverage of that Eligible Employee, Spouse, or Dependent under the Plan.

The following Status Changes apply only to medical, dental, vision, and dependent care reimbursement benefits:

(a) **Cost changes.** The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "significant" change for purposes of this subsection.

(1) **Automatic changes.** If the cost for a Benefit shall increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, make a corresponding change in the amount of salary reductions accruing for the remainder of the Plan Year.

(2) **Significant cost changes.** If the cost for a Benefit significantly changes during a Plan Year, an Eligible Employee may revoke his/her election and, in lieu thereof, make a corresponding change in election under the Plan. Changes that may be made include commencing participation in a Benefit with a decrease in cost, or, in the case of an increase in cost, revoking an election for that Benefit and, in lieu thereof, either receiving on a prospective basis coverage under another Benefit providing similar coverage or dropping coverage if no other Benefit providing similar coverage is available.

(3) **Application to Dependent Care Reimbursement Plan.** A Participant may elect to increase contributions to the Dependent Care Reimbursement Plan if there is a significant increase in the cost of dependent care that is not provided by a Relative of the Participant. The cost increase may result from the Participant electing to increase the compensation paid to the dependent care provider. For purposes of this provision, a "Relative" of the Participant is any individual who is related to the Participant in one of the ways described in Code Sections 152(a)(1) through (8), utilizing the rules in Code Sections 152(b)(1) and (2).

(b) **Coverage changes.**

(1) **Significant curtailment without loss of coverage.** If an Eligible Employee (or his/her Dependent) has a significant curtailment of coverage under a benefit plan during a Plan Year that is not a loss of coverage, the Eligible Employee may revoke his/her election for such significantly curtailed coverage and, in lieu thereof, elect to receive coverage on a prospective basis under another available benefit plan providing similar coverage.

(2) **Significant curtailment with loss of coverage.** If an Eligible Employee (or his/her Dependent) has a significant curtailment of coverage under a benefit plan during a Plan Year that is a loss of coverage, the Eligible Employee may revoke his/her election for such significantly curtailed coverage and, in lieu thereof, either elect to receive coverage on a prospective basis under another available benefit plan providing similar coverage or, if no such other benefit plan exists, to drop coverage entirely.

(3) **Addition/improvement of benefit.** If a new Benefit is added or if coverage under an existing Benefit is significantly improved during a Plan Year, an Eligible Employee may revoke his/her election under the Plan and, in lieu thereof, make an election for coverage under the new or improved Benefit.

(4) **Change in coverage under another employer plan.** An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the County or another employer) if: (i) the other plan permits participants to make an election change that would be permitted under this Section 2.19, disregarding this provision; or (ii) the other plan permits participants to make an election for a plan year that is different than the Plan Year under the Plan.

(5) **Definition of significant curtailment.** Coverage under a benefit plan is significantly curtailed for purposes of this subsection only if there is an overall reduction in coverage provided under such benefit plan so as to constitute reduced coverage

generally (for example, a significant increase in the deductible, the copayment, or the out-of-pocket cost sharing). The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "significant" curtailment in coverage for purposes of this subsection.

(6) **Definition of loss of coverage.** A loss of coverage for purposes of this subsection means a complete loss of coverage under the elected benefit plan (including the elimination of a benefit plan or an HMO ceasing to be available in the area where the individual resides). A loss of coverage also means a substantial decrease in the medical care providers available under the benefit plan (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO). A loss of coverage shall include coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "loss of coverage" for purposes of this subsection.

The following Status Changes apply only to the medical benefit:

(a) **Enrollment in marketplace coverage.** A Participant may revoke his/her election for medical coverage (but not for coverage under the Health Care Reimbursement Plan) for him/herself and his/her Dependents in order to purchase a qualified health plan through a marketplace established under Section 1311 of the Patient Protection and Affordable Care Act of 2010; provided that the Participant certifies that s/he and his/her Dependents have enrolled or intend to enroll in a qualified health plan under the marketplace that is effective beginning no later than the day immediately following the last day of the Plan's medical coverage that is revoked.

(b) **Reduction in work hours**. A Participant may revoke his/her election for medical coverage (but not for coverage under the Health Care Reimbursement Plan) for him/herself and his/her Dependents due an employment status change; provided that: (i) the Participant had been in an employment status with the County under which s/he was reasonably expected to average at least 30 hours of service per week and there is a change in his/her employment status so that s/he is reasonably expected to average less than 30 hours of service per week, even though the reduction in hours does not result in him/her ceasing to be eligible for medical coverage under the Plan; and (ii) the Participant certifies that s/he and his/her Dependents have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the Plan's medical coverage is revoked.

ARTICLE III
PARTICIPATION

3.1 Eligibility.
Each Employee 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 by Exempt Management, Management, Confidential, Unrepresented Resolution ("Management Resolution")

shall be eligible to participate in the Plan if the Employee is eligible to participate in the County's medical, dental, vision, health care reimbursement, and dependent care reimbursement benefits and so long as the Employee is employed by the County as of his/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 executing a 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 Eligible Employee's initial election period, the remaining portion of the Plan Year that contains the Eligible Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the County to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. An Eligible Employee must execute the Benefit Enrollment Application and a Salary Reduction Agreement within 60 days of the Entry Date.

3.3 Irrevocability of Elections.
A Participant (or an Eligible Employee with respect to an election not to participate in the Plan) may not modify his/her Benefits elections at any time during the Plan Year, except as provided for under Section 4.3.

3.4 Election Change Procedure for Forthcoming Plan Years.
If a Participant wants to change his/her elections for a forthcoming Plan Year (or an Eligible Employee want to enroll for the forthcoming Plan Year), the Participant or Eligible Employee 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 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 or Eligible Employee 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 Health Care Reimbursement Plan or Dependent Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

3.5 Changes in Elections by Plan Administrator

Notwithstanding any other provision of the Plan, the Plan Administrator may take such action, as appropriate in the discretion of the Plan Administrator, to rectify erroneous salary reduction contributions, contributions and credits to the extent permitted by applicable law.

3.6 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 Eligible Employee, resigns, or terminates employment with the County, subject to the provisions of Section 3.3;
(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.

3.7 Participation by Rehired Employees.

If a terminated Eligible Employee is rehired by the County in the same Plan Year and within 30 days following his/her termination of employment, such Eligible Employee shall 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. If a terminated Eligible Employee is rehired by the County either more than 30 days following his/her termination of employment or in a new Plan Year, such Eligible Employee shall be a new Eligible Employee and shall make new elections to participate in the Plan.

3.8 HIPAA Special Enrollment Rights.

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 have special enrollment rights and shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA, as reflected in PHSA Section 2704(f).

3.9 COBRA Continuation Coverage.

Notwithstanding any other provisions in this Article III, any Participant, Spouse, or Dependent eligible for continuation coverage under Code Section 4980B shall be allowed to continue to participate in the health care Benefits, so long as such Participant, Spouse, or Dependent

complies with the provisions set out in PHSA Sections 2201–2208.

The County shall adopt rules relating to continuation coverage for health care Benefits, as provided under PHSA Sections 2201–2208 (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.

3.10 Family Medical Leave Act.
Subject to any provision in the Code governing Family and Medical Leave Act ("FMLA") and California Family Rights Act ("CFRA") leave coverage to the contrary, FMLA/CFRA continuation coverage of health care Benefits 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 the leave, through a pre-tax or an after-tax Salary Reduction Agreement, from any taxable Compensation, provided all other Plan requirements are met; or
(b) Participants may pay their share of contributions on the same schedule as payments would be made if the Participant were not on leave or under another schedule permitted under Department of Labor regulations and approved by the Plan Administrator.

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

The County shall not be required to continue the coverage of a Participant who fails to make required contributions while on FMLA, CFRA, or other leave. However, if the County chooses to continue the coverage of a Participant who fails to make required contributions while on leave, the County is entitled to recoup those payments after the Participant returns from leave.

3.11 Uniformed Services Employment and Reemployment Rights Act ("USERRA").
If a Participant takes a military leave of absence or the Participant terminates employment to enter into military service, the Participant may elect to continue coverage of the health care Benefits in accordance with the requirements of USERRA or other applicable law. The County shall notify the Participant in advance, in writing, of the terms and conditions of contributions during the military leave and shall comply with USERRA for both continuation of health care Benefits and reinstatement rights.

ARTICLE IV
CONTRIBUTIONS

4.1 Source of Contributions.
The County 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 and Salary Reduction Agreement 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 Benefits Accounts as the County deems appropriate.

4.2 Spending Credits.
Prior to the beginning of each Plan Year or a Participant's Entry Date, the County 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 elect Benefits (other than Compensation) available under the Plan and apply Spending Credits towards the cost of the elected Benefits by executing a Benefits Enrollment Application and returning it to the Plan Administrator. Spending Credits not applied by the Participant toward the cost of Benefits shall be paid as Compensation, but only if the Participant elects at least one of the Benefits and submits a Benefits Enrollment Application to the Plan Administrator.

Eligible Employees electing not to enroll in 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 Resolution governing their bargaining unit. They must also provide evidence of medical coverage through their Spouses or other sources and sign a statement that they are enrolled and covered under another medical plan, within 60 days of the election.

The County shall provide Spending Credits for each Participant in the amount determined by the Board of Supervisors, based on the Participant's unit/classification. Included within the monthly Spending Credit 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/Eligible Employee's Benefits Enrollment.
No Participant shall be allowed to alter or discontinue the Participant's elected Benefits under the Plan during a Plan Year, and no Eligible Employee shall be allowed to alter an election of "no coverage" during a Plan Year, except when due to and consistent with a Status Change as outlined in Section 2.19 or in accordance with a special enrollment right under Section 3.8.

Upon the occurrence of a Status Change or a special enrollment right, the Participant or Eligible Employee may file a new Benefits Enrollment Application, which will serve to revoke the Participant's or Eligible Employee'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 or special enrollment right, 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, Spouse, or Dependents after the effective date of the new Benefits Enrollment Application.

With respect to a special enrollment right, "timely submitted" shall mean submitted no later than 60 days from the date of the occurrence of the special enrollment right, as determined by the Plan Administrator. With respect to a Status Change, "timely submitted" shall mean submitted no later than 60 days from the date of the 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 or special enrollment right.

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.

4.4 Increases or Decreases in Cost of Benefits.
Should a third party benefit provider, such as an insurance company, increase or decrease the cost of any Benefit during the Plan Year, any Participant participating in such Benefit shall have his/her salary reduction contributions increased or decreased automatically in an amount corresponding to such increase or decrease, unless such increase or decrease is "significant" in accordance with Section 2.19.

4.5 Maximum Contribution.
The maximum contribution any Participant can make under the Plan is an amount equal to the sum of the costs for each of the highest cost Benefits offered under the Plan plus the sum of the salary reduction contributions made to the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan.

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. Notwithstanding any other provision of the Plan, if the Plan Administrator determines at any time that the Plan, or any portion of the Plan, may fail to satisfy any nondiscrimination requirement imposed on the Plan, or such portion of the Plan, by the Code or any other applicable law, the Plan Administrator may take such action, as appropriate in the discretion of the Plan Administrator, to comply with the applicable requirement. Such action may include, without limitation, a modification of the elections of "highly compensated employees" or "key employees" (as defined in the relevant Section of the Code), without the consent of the affected individuals. In addition, if necessary to comply with the nondiscrimination provisions of Code Section 125, Plan benefits provided to regular part-time Employees and Plan benefits provided to regular full-time Employees shall be deemed to be provided by two separate plans.

4.7 Tax Treatment.
While it is County's intent that Benefits will be eligible for exclusion from the gross income of the Participant, the County cannot guarantee or ensure that any of the Benefits provided under the Plan will not be subject to income or other taxes, as further set forth in Section 7.15.

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

If any Participant receives one or more benefit payments under the Plan that are not for a "qualified benefit" as defined by Code Section 125, such Participant shall indemnify and reimburse the County for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such benefit payments. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the benefit payments had been made to the Participant as Compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

ARTICLE V
PARTICIPANTS' BENEFIT ACCOUNTS AND PAYMENT OF BENEFITS

5.1 Participants' Benefit Accounts.
The Plan Administrator shall establish separate Benefits Accounts based on the Benefits elections 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". In no event shall a Participant be permitted to utilize the Benefit Accounts to pay for "nonqualified benefits", as that term is defined in and applicable to Code Section 125.

5.2 Premium Account.
A "Premium Account" is an account established with the intent of paying pre-tax for premium-type Benefits pursuant to an insurance policy issued by an insurance company; under a contract with a health maintenance, preferred provider, or point-of-service organization; or as employee contributions toward the cost of Benefits paid out of the general assets of the County to provide medical, dental, vision, or other Benefits as described in enrollment material.

5.3 Reimbursement Account.
A "Reimbursement Account" is an account established with the intent of providing reimbursement of allowable expenses pursuant to the Health Care Reimbursement Plan or Dependent Care Reimbursement Plan.

5.4 Payment of Benefits.
The Plan Administrator shall make the benefit payments authorized under the Plan other than insurance Benefits administered by a third-party benefit provider. Payments for the cost of insurance Benefits shall be made by the County (or the Plan Administrator) in a timely manner upon receipt of a premium notice from the benefit provider. 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 Participant's medical bills; or

(d) Spouse or Dependent with COBRA continuation rights.

5.5 Coverage Provided.
While an election for Benefits may be made under the Plan, the Benefits are not provided by the Plan. The provisions of each medical, dental, and vision Benefit available under the Plan are described in the individual benefit plan descriptions. Reimbursement-type Benefits are described in separate plan documents, which are attached to this document as Schedule A and Schedule B.

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.
It shall be a principal duty of the Plan Administrator to see that the Plan is administered, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan, without discrimination among such persons. 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 make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures;

(b) To construe and interpret the Plan, to decide all questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision;

(c) To construe and interpret the Plan, to decide all questions of eligibility and participation, and to determine the Benefits to be covered by the Plan;

(d) To determine the amount, manner, and time for benefit payments under the Plan, and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;

(e) 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;

(f) To determine the rights of any Participant, Spouse, Dependent, or beneficiary to Benefits or payments under the Plan;

(g) To develop appellate and review procedures for any Participant, Spouse, Dependent, or designated beneficiary denied Benefits or payments under the Plan;

(h) To prepare and distribute information explaining the Plan and the Benefits in such manner as the Plan Administrator deems to be appropriate;

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

(j) To furnish each Participant with such reports as the Plan Administrator deems to be reasonable and appropriate;

(k) To receive, review, and keep on file such reports and information concerning the Benefits as the Plan Administrator determines to be necessary and proper;

(l) To appoint or employ any agents, attorneys, accountants, or other parties (who may also be employed by the County) 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 shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by any such experts employed or engaged by the Plan Administrator.

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

6.3 Information to be Provided to Plan Administrator.
The County, or any of its agents, shall provide to the Plan Administrator any employment records of any Eligible Employee. Such records shall include, but will not be limited to, any information regarding periods 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 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 the Plan made in good faith by the Plan Administrator as to any Participant's rights or Benefits under the 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 it considers equitable and practicable.

6.5 Review Procedures.
All eligibility and enrollment-related claims under the Plan shall be determined by the Plan Administrator, in its sole discretion.

With respect to the denial of any claim for Benefits paid for through a Premium Account or any claim for payments from an insurance company or other third-party benefit provider, the review procedures of the insurance company or other third-party benefit provider shall apply, as described in the individual benefit plan descriptions.

The review procedures for claims under the Health Care Reimbursement Plan shall be administered as follows. In cases where the Plan Administrator denies a Benefit or

reimbursement under the Plan for any claimant, the Plan Administrator shall furnish in writing to the claimant the reasons for the denial of the Benefit or reimbursement. The written denial shall be provided within 30 days of the date of the denial by the Plan Administrator. The written denial shall refer to the Plan section 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 its final decision on the reviewed claim.

The review procedures for claims under the Dependent Care Reimbursement Plan shall be determined by the Plan Administrator, in its sole discretion.

No claimant shall initiate any action or proceeding in any state or federal court of law or equity, or before any administrative tribunal, for a claim for Benefits or payments under the Plan until the claimant has first exhausted the review procedures as set forth above. Any lawsuit to recover Benefits or payments shall be filed within three (3) years of the date that the claimant has exhausted the above review procedures, unless an applicable state statute of limitations provides for a different period in which to file.

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

6.7 Employment of Assistants.
The Plan Administrator is authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Benefit provision.

6.8 Indemnity.
The County shall indemnify and hold harmless, to the extent allowed by law, any Employee designated by the County or the Plan Administrator to assist in the fulfillment of the administration of the 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 County 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.

6.9 Plan Administrator Compensation; Plan Expenses.
The Plan Administrator shall serve without compensation. However, all reasonable expenses for Plan administration, including reasonable compensation for hired services, will be paid by the Plan.

6.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of a person, the Plan Administrator shall, to the extent that it deems it administratively possible and as otherwise permissible under the Code, cause to be allocated, cause to be withheld or accelerated, or otherwise make adjustment of such eligibility, participation, or amounts as it shall in its judgment accord to such person and to which such person is properly entitled under the Plan. Such action by the Plan Administrator may include the withholding of any amounts due to the Plan or the County. The ability of the Plan Administrator to make such corrections shall be based on several factors, including:

(a) The reasonableness of the mistake;
(b) Whether the mistake is discovered within a reasonable time after the beginning of the coverage period under the Cafeteria Plan;
(c) Whether the person has claimed other similar mistakes in prior coverage periods under the Cafeteria Plan; and
(d) Whether other persons have made similar mistakes in the past.

6.11 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data shall be available to any Participant or Employee at reasonable times during normal business hours at the business office of the Plan Administrator or by contacting the Plan Administrator.

ARTICLE VII
GENERAL PROVISIONS

7.1 Amendment and Termination.
The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, the County may amend or terminate the Plan at any time by legal action of the authorized agents of the County, subject to the limitation that no amendment shall change the terms and conditions of payment of any Benefit that 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 County may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Code Section 125 or any other Code provision applicable to the Plan.

7.2 Nonassignability.
Any benefit payments to any Participants under the Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents, and designated beneficiaries. No benefit payment 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:

(a) Relates to the provision of child support related to health care Benefits for a child of a Participant;
(b) Is made pursuant to a state domestic relations law; and
(c) Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive health care Benefits under which a Participant or other beneficiary is entitled to receive benefit payments.

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 ("QMCSO") 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 claim review procedures 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 offered by the Plan.

Any such 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 Benefits to be provided by the Plan or the manner in which such Benefits are to be determined, the period of coverage that must be provided, and each Benefit 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 Participant to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment period restrictions.

7.4 Not an Employment Contract.
By creating the Plan and providing Benefits under the Plan, the County in no way guarantees employment for any Employee. Participation in the Plan shall in no way assure continued employment with the County.

7.5 Participant Litigation.
In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees 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 County, through its Risk Management department at P.O. Box 1210, Riverside, CA 92502, 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 County and any interested party to the Plan.

7.6 Addresses, Notice and Waiver of Notice.
Each Employee shall furnish the County with his/her correct post office address. Any communication, statement, or notice addressed to an Employee at his/her last post office address as filed with the County will be binding on such person. The County or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under the 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 County such documents, evidence, or information as the County considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the County.

7.8 Severability.
In any case where any provision of the 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. To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced, and administered according to the laws of the State of

California.

7.11 Trust Provisions.
In the event that the Plan Administrator determines, in its sole and absolute discretion, that the Plan is required by law to establish and maintain a trust to hold contributions by Participants or to make benefit payments, as defined under applicable law, the Plan Administrator may establish a trust for this purpose. Any interest earned on amounts placed in such trust shall be used for any purpose as set forth in the trust.

7.12 No Vested Rights.
To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or a Benefit, or acquire any right, title, or interest in or to any Benefit referred to or provided for in the Plan or any Benefit otherwise than by actual payment of such Benefit. Further, no person has any right, title, or interest in or to the assets of the County because of the Plan.

7.13 Misrepresentation or Fraud.
A person who receives a benefit under the Plan as a result of false information or misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

7.14 Force Majeure.
Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

7.15 No Guarantee of Tax Consequences.
Neither the County nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan or any Benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's income for federal, state, and/or local income tax purposes, and to notify the County if the Participant has reason to believe that any such payment treated by the County as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which the County had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the County, such Participant shall pay all such taxes (including any related penalties and interest) directly or reimburse the County for any such taxes (including any related penalties and interest) paid by the County.

7.16 Incorporation by Reference.
The County of Riverside Health Care Reimbursement Plan and The County of Riverside Dependent Care Reimbursement Plan, as each is amended from time to time, are hereby specifically incorporated into the Plan by reference. These documents will be incorporated into the Plan to the extent that such document references the Plan and specifies the ability to or specifies the ability to pay for Benefits on a pre-tax basis and contribute to the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account.

7.17 Responsibility for Health Care.
The provisions of any health Benefit program under the Plan shall not be construed to limit a Participant with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Participant and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Participant shall be solely responsible for deciding the health care that the individual receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits will be paid under the Plan and is not intended to be advice to an individual concerning that individual's health care treatment. Each Participant shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that individual.

Executed this 15TH day of December, 2020

COUNTY OF RIVERSIDE

V. M. P.

Chairman, Board of Supervisors

V. MANUEL PEREZ

ATTEST:
KECIA R. HARPER, Clerk
By _____ DEPUTY

FORM APPROVED COUNTY COUNSEL
BY: Lisa Sanchez 12/03/2020
LISA SANCHEZ DATE

Schedule A
to
The County of Riverside Flexible Benefit Program

THE COUNTY OF RIVERSIDE
HEALTH CARE REIMBURSEMENT PLAN

Amended and Restated Effective January 1, 2021

TABLE OF CONTENTS

ARTICLE I
INTRODUCTION

1.1 Creation and Title.
The County of Riverside, a political subdivision of the State of California (the "County"), previously established and has maintained The County of Riverside Health Care Reimbursement Plan (the "Health Care Reimbursement Plan"). The County hereby amends the Health Care Plan under the terms and conditions set forth in this Schedule A.

1.2 Effective Date.
The provisions of the Health Care Plan, as amended and restated, shall be effective as of January 1, 2021. The Health Care Plan was originally effective January 1, 2000.

1.3 Purpose.
The purpose of the Health Care Plan is to provide reimbursement for Qualified Expenses. The County intends that the Health Care Plan qualify as a medical reimbursement plan under Code Section 105 and that the nontaxable benefits provided under the Health Care Plan be eligible for exclusion from Participants' income under Code Sections 105(b) and 106(a).

The provisions of the Health Care Plan, as reflected in this Schedule A, are applicable only to Eligible Employees who are in the active employ of the County on or after January 1, 2021.

1.4 Incorporated Document.
The Health Care Plan is part of and incorporated by reference into The County of Riverside Flexible Benefit Program. The provisions of The County of Riverside Flexible Benefit Program apply to the Health Care Plan.

To the extent required by Code Section 125, this Schedule A, and the applicable provisions of The County of Riverside Flexible Benefit Program constitute the plan documents for the Health Care Plan.

1.5 Participation.
Eligible Employees are eligible to participate in the Health Care Plan during periods of participation under The County of Riverside Flexible Benefit Program. Participation occurs when, and to the extent that, an Eligible Employee elects to allocate to the Health Care Plan a portion of the salary reduction contributions available to him/her under The County of Riverside Flexible Benefit Program as premium payments hereunder.

ARTICLE II
DEFINITIONS

Except as otherwise specified below, all terms when capitalized shall have the meaning stated in Article II of The County of Riverside Flexible Benefit Program.

2.1 "Grace Period" means the provisions that allows a Participant to use amounts remaining from the Plan Year for expenses incurred during an additional 2.5 month period immediately following the Plan Year (i.e., January 1 through March 15 of the following Plan Year), in accordance with IRS Notice 2013-71.

2.2 "Health Care Plan" means The County of Riverside Health Care Reimbursement Plan, as described herein, part of and incorporated by reference into The County of Riverside Flexible Benefit Program.

2.2 "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.

2.3 "Health Care Reimbursement Benefits Account" means the notional account established by the Plan Administrator under the Health Care Plan for each Participant to which contributions made according to the Participant's Salary Reduction Agreement and from which reimbursements of Qualified Expenses, shall be recorded. However, in no event shall actual accounts be established or funded.

2.4 "Qualified Expenses" means the medical expenses incurred by a Participant, Spouse, or Dependent, otherwise allowed as a deduction for medical expenses under Code Section 213(d). For purposes of this definition, Qualified Expenses include amounts paid:

(a) For the diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body; and
(b) For transportation primarily for and essential to such care.

Notwithstanding the foregoing, medical care shall not include:

- The Participant's premium payments for other health coverage, including premiums paid for health coverage under a plan maintained by an employer of the Participant's Spouse or Dependent;
- Qualified long-term care services pursuant to the terms of Code Section 213(d)(1)(C);
- Cosmetic surgery pursuant to the terms of Code Section 213(d)(9); or
- Amounts paid for lodging away from home primarily for and essential to medical care pursuant to the terms of Code Section 213(d)(2).

Qualified Expenses must:

- Be incurred during a Plan Year in which the Participant participates in the Health Care Plan;
- Not be reimbursed under any other plan maintained by the County or from any other

source;

- Not be incurred prior to the commencement of the Participant's participation in the Health Care Plan or after the Participant's participation in the Health Care Plan ends; and
- Not be in excess of the elected amount of coverage in effect at the time the Qualified Expense is incurred, less the amount of reimbursements previously made for such Plan Year.

For purposes of the Health Care Plan, a Qualified 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, Spouse, or Dependent.

ARTICLE III
HEALTH CARE REIMBURSEMENT BENEFITS

3.1 Provision of Health Care Reimbursement Benefits.
Health Care Reimbursement Benefits shall take the form of the reimbursement of Qualified Expenses incurred by a Participant, Spouse, and Dependents during the Plan Year or corresponding Grace Period. A Participant or former Participant shall be entitled to reimbursement of Qualified Expenses incurred only while a Participant, unless continuation coverage is elected pursuant to Section 3.5 of The County of Riverside Flexible Benefit Program and Code Section 4980B (or applicable state law). In accordance with Code Section 4980B, a former Participant shall be entitled to elect continuation coverage under the Health Care Plan only until the end of the Plan Year and corresponding Grace Period in which the former Participant's termination of employment occurred.

Upon termination of employment, a Participant's Health Care Reimbursement Benefits Account will remain open for the remainder of the Plan Year (including the corresponding Grace Period) in which the 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 noted above.

3.2 Amount of Health Care Reimbursement Benefits.
The maximum amount of coverage elected by an Eligible Employee for a Plan Year for which salary reduction contributions are allocated as premium payments under the Health Care Plan shall be equal to an amount not in excess of $2,500, or such other maximum amount as indexed annually and permitted by applicable law. The amount of a Participant's Health Care Reimbursement Benefits shall be uniformly available during the Plan Year.

The Plan Administrator may specify substantially equal whole dollar allocation amounts on a per contribution period basis for the amount of coverage elected by an Eligible Employee such that the Plan Year maximum is satisfied.

3.3 Nondiscrimination.
The Health Care Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and Health Care Reimbursement 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 Health Care Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Health Care Plan does not violate applicable nondiscrimination rules.

3.4 Transfers
An amount that is credited to an Participant's Health Care Reimbursement Benefits may not be transferred to any other account, to any Benefit available under the Plan, or to any other Participant under any circumstances; nor may any amount allocable to the Plan Year be reallocated to any other Plan Year.

ARTICLE IV
FUNDING AND PAYMENT OF HEALTH CARE REIMBURSEMENT BENEFITS

4.1 Funding.
The County shall contribute amounts necessary to fund the Health Care Plan, as determined by the Salary Reduction Agreements entered into by Participants for the Plan Year. Contributions to the Health Care Plan shall be held in the general assets of the County, unless the County should determine that a trust is required to be established for the Health Care Plan.

4.2 Participants' Accounts.
The Plan Administrator shall establish a separate Health Care Reimbursement Benefits Account for each Participant in the Health Care 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 Salary Reduction Agreement and Benefits Enrollment Application. The Plan Administrator shall debit a Participant's Health Care Reimbursement Benefits Account in the amount of any reimbursements for Qualified Expenses 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 below, except when the reimbursement results in a zero balance.

4.3 Reimbursements.
Reimbursement shall only be made under the Health Care Plan on the basis of Qualified Expenses incurred by the Participant, Spouse, or Dependents, as presented to the Plan Administrator in the manner 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 Qualified Expenses have been incurred;
(b) The nature of the Qualified Expenses incurred;
(c) The date the Qualified Expenses were incurred;
(d) The amount of the requested reimbursement; and
(e) That the Qualified Expenses have not been otherwise paid through an insurance program offered by the County 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 Health Care Plan.

Notwithstanding the above provisions, the Plan Administrator may establish procedures for the use of a debit card for the reimbursement of Qualified Expenses. The aggregate reimbursement

of Health Care Plan with respect to a Plan Year on behalf of a Participant shall not exceed the aggregate amount of the Participant elected under the Salary Reduction Agreement for the Plan Year.

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 Participant's medical bills; or
(d) Spouse of the Participant with COBRA continuation rights.

4.4 Timing of Claims and Forfeiture of Health Care Reimbursement Benefits.
If, as of the end of the Plan Year, a Participant has not incurred Qualified Expenses equal to the amount credited to his/her Health Care Reimbursement Benefits Account, the Participant shall be given a Grace Period in which to incur Qualified Expenses to submit for reimbursement against that remaining balance. 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 15th following the end of the Plan Year. Any remaining balance credited to the Participant's Health Care Reimbursement Benefits Account after the Grace Period for that Plan Year shall be forfeited.

Notwithstanding the above, Participants who terminate employment prior to the end of the Plan Year (including the corresponding Grace Period) and do not continue coverage in accordance with Code Section 4980B 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 ($0.00). At the discretion of the County, forfeitures of Health Care Reimbursement Benefits may be reallocated to Participants in any reasonable manner. Forfeitures may also be applied towards the cost of administering the Health Care Plan. All forfeitures shall become the sole property of the County.

ARTICLE V
DISCLOSURE OF PROTECTED HEALTH INFORMATION

5.1 Definitions.
Whenever used in this Article V, the following terms shall have the respective meanings set forth below. All terms used and capitalized but not otherwise defined in this Article shall have the same meaning as those terms in 45 CFR Parts 160 and 164.

(a) **Plan Administration Functions** means administrative functions performed by the County on behalf of the Health Care Plan, excluding functions performed by the County in connection with any other benefit or benefit plan of the County.

(b) **Health Information** means information (whether oral or recorded in any form or medium) that is created, maintained, or received by a health care provider, health plan (as defined in 45 CFR Section160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR Section160.103) 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 Health 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 County provides benefits under the Health Care 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 County 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.

5.2 General Rule.
The Health Care Plan shall use, disclose, store, retain, and, if applicable, destroy a person's PHI in accordance with 45 CFR Parts 160 and 164.

5.3 Use or Disclosure for Payment and Health Care Operations.
The Health Care Plan may use or disclose PHI without the consent or authorization of the person for purposes of Payment, Health Care Operations, and any other purpose for which use or disclosure is permitted or required under 45 CFR Parts 160 and 164.

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

The Health Care Plan will disclose PHI to the County only in accordance with 45 CFR Section164.504(f) and the provisions of this Article.

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

(a) Claims Processing;
(b) Plan Auditing; and
(c) Quality Assurance.

5.5 County Certification and Responsibility.
The Health Care Plan may only disclose such PHI to members of the County's workforce (as designated in Section 5.6) involved in Plan Administration Functions, and only those designated members of the workforce shall have access to such PHI. The amount of PHI that the Health Care Plan discloses to the Company for such purpose shall not exceed the Minimum Necessary amount of PHI to accomplish the intended purpose of the disclosure. No such disclosure shall occur unless and until the Health Care Plan receives a certification from the County stating provisions (a) through (j) below. The Health Care Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the County and acknowledges receipt of written certification from the County that the Health Care Plan has been so amended.

Additionally, the County agrees:

(a) Not to use or further disclose PHI other than as permitted in this Article or as required by law;
(b) To ensure that any of its agents or subcontractors to whom it provides PHI received from the Health Care 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 Health Care Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures in this Article;
(e) To make PHI available to individuals in accordance with 45 CFR Section164.524;
(f) To make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR Section164.526 and shall incorporate any amendments to PHI it holds, as required in 45 CFR Section164.526;

(g) To make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR Section164.528;
(h) To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Care Plan available to the Secretary of the U.S. Department of Health and Human Services upon request;
(i) If feasible, to return or destroy all PHI received from the Health Care Plan that the County maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, the County will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible; and
(j) To ensure that adequate separation between the Health Care Plan and the County, as required by 45 CFR Section164.504(f), is established and maintained.

5.6 Employees With Access to PHI.
The Health Care Plan will disclose and grant access to PHI only to the Employees or classes of Employees as listed in the Health Care Plan's HIPAA policies and procedures.

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

5.7 Noncompliance.
Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Article by persons described in Section 5.4 shall be addressed in compliance with the Health Privacy and Security Policy most recently adopted by the County Board of Supervisors.

5.8 Data Security Standards.
The County, as the plan sponsor, shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Health Care 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 electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
(d) Report to the Health Care Plan any security incident of which it becomes aware.

5.9 Health Information Technology for Economic and Clinical Health (HITECH) Act.
The County shall comply with the breach notification provisions as set forth in the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009.

5.10 Nondisclosure of Genetic Information for Underwriting Purposes.
The Health Care Plan shall not use or disclose PHI that is Genetic Information (as set forth in 45 CFR Section 160.103) for underwriting purposes, as defined in 45 CFR Section 164.502(a)(5)(i).

Executed this 15TH day of December, 2020

COUNTY OF RIVERSIDE

Chairman, Board of Supervisors
V. MANUEL PEREZ

ATTEST:
KECIA R. HARPER, Clerk
By _____
DEPUTY

FORM APPROVED COUNTY COUNSEL
BY: _____ 12/03/2020
LISA SANCHEZ DATE

Schedule B
to
The County of Riverside Flexible Benefit Program

THE COUNTY OF RIVERSIDE
DEPENDENT CARE REIMBURSEMENT PLAN

Amended and Restated Effective January 1, 2021

TABLE OF CONTENTS

ARTICLE I
INTRODUCTION

1.1 Creation and Title.
The County of Riverside, a political subdivision of the State of California (the "County"), previously established and has maintained The County of Riverside Dependent Care Reimbursement Plan (the "Dependent Care Reimbursement Plan"). The County hereby amends the Dependent Care Reimbursement Plan under the terms and conditions set forth in this Schedule B.

1.2 Effective Date.
The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2021. 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, 2021.

2.10 **"Eligible Employee"** means an Employee, as defined in Section 2.11 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 No. 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 1st

and ending December 31st.

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 15th 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 ($0.00). 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.

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.

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.

Executed this 15TH day of December, 2020

Employer: COUNTY OF RIVERSIDE

Chairman, Board of Supervisors
V. MANUEL PEREZ

ATTEST:
KECIA R. HARPER, Clerk
By _____
DEPUTY

FORM APPROVED COUNTY COUNSEL
BY: _____ 12/03/2020
LISA SANCHEZ DATE