



cityofnovi.org

CITY of NOVI CITY COUNCIL

Agenda Item J February 6, 2012

SUBJECT: Resolution to approve Cafeteria Plan (Section 125) and Flexible Spending Plan as amended.

SUBMITTING DEPARTMENT: Human Resources 

CITY MANAGER APPROVAL: 

BACKGROUND INFORMATION:

The City amended its Flexible Benefit Plan prepared by BCI effective January 1, 2002. Pursuant to IRS rules in order to provide this benefit to employees a Cafeteria Plan must be established. Cafeteria Plans were added to the Internal Revenue Code in November 1978. Internal Revenue Code Section 125 sets forth the requirements and tax treatment of cafeteria plans. Section 125 has been amended multiple times since its enactment. Employees may elect to participate in benefits such as the Flexible Benefit Plan and, by doing so, their monetary election is excluded from gross income.

A Section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a Section 125 plan.

The City's Flexible Spending Plan document is being amended to include the City's Health Savings Account (HSA).

RECOMMENDED ACTION: Resolution to approve Cafeteria Plan (Section 125) and Flexible Spending Plan as amended.

	1	2	Y	N
Mayor Gatt				
Mayor Pro Tem Staudt				
Council Member Casey				
Council Member Fischer				

	1	2	Y	N
Council Member Margolis				
Council Member Mutch				
Council Member Wrobel				

CITY OF NOVI

COUNTY OF OAKLAND, MICHIGAN

RESOLUTION TO APPROVE CAFETERIA PLAN BASIC PLAN DOCUMENT 125 AND FLEXIBLE SPENDING PLAN (AS AMENDED)

Minutes of a Meeting of the City Council of the City of Novi, County of Oakland, Michigan, held in the City Hall of said City on _____, _____, at ____ o'clock P.M. Prevailing Eastern Time.

PRESENT: Councilmembers _____

ABSENT: Councilmembers _____

The following preamble and Resolution were offered by Councilmember _____ and supported by Councilmember _____.

WHEREAS IT IS RESOLVED, the City Council adopts and approves the following: City of Novi Cafeteria Plan 125 plan document is approved, and the City of Novi Flexible Spending Plan has been amended and restated in the form attached hereto;

RESOLVED FURTHER, that the Director of Human Resources is authorized and directed to execute the plan on behalf of the City;

RESOLVED FURTHER, that the Director of Human Resources is authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports documents or other information as may be required under applicable law.

NOW THEREFORE, IT IS THEREFORE RESOLVED that the City of Novi Cafeteria Plan Document and Flexible Spending Plan Document are approved

AYES:

NAYS:

RESOLUTION DECLARED ADOPTED.

Maryanne Cornelius, City Clerk

CERTIFICATION

I hereby certify that the foregoing is a true and complete copy of a resolution adopted by the City Council of the City of Novi, County of Oakland, and State of Michigan, at a regular meeting held this ____ day of _____, 2012, and that public notice of said meeting was given pursuant to and in full compliance with Act No. 267, Public Acts of Michigan, 1976, and that the minutes of said meeting have been kept and made available to the public as required by said Act.

Maryanne Cornelius, City Clerk
City of Novi

CITY OF NOVI
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2011

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CITY OF NOVI
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

City of Novi (the "Company") established the City of Novi Flexible Benefit Plan (the "Plan") effective January 1, 2002. This Summary Plan Description describes the Plan as amended and restated effective January 1, 2011.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are employed by City of Novi or any affiliate who has adopted the Plan. However, you are not an "Eligible Employee" if you are any of the following:

A leased employee.

A non-resident alien who received no U.S. earned income.

A part-time employee who is expected to work less than 37.5 hours per week.

Employee's not eligible under the Employer's group medical plan.

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan on the date you first perform an hour of service as an Eligible Employee.

However, you will become a Participant eligible to make contributions and receive benefits from the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

ELECTIONS

In General

When you become eligible to participate in the Plan, you may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

When you are first eligible to participate in the Plan, you must return a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you have not returned an election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the FMLA

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

BENEFITS

Premium Conversion Account

When you become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

Employer Group Medical

Employer Dental

Employer Vision

Employer Disability

Employer Group Term Life

Individually-owned Medical

Individually-owned Disability

Other coverages as defined by AFLAC

If a contract is offered in conjunction with a Company-sponsored benefit plan, you will be eligible to make contributions to the Premium Conversion Account only if you are also eligible to participate in the applicable Company-sponsored plan, it is described above and you are eligible to participate in this Plan.

In the event of a conflict between the terms of this Plan and the terms of a contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Care Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a Health Care Reimbursement Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the calendar year. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available for reimbursement. The maximum amount you may contribute each year is \$3,000.

Please note that this Plan works in coordination with a high deductible health plan which allows you to participate in a Health Savings Account. As a result, until the minimum annual deductible is met (\$1,200 for a single person and \$2,400 for family coverage in 2012) in the high deductible health plan, coverage in the Plan is only provided for benefits that are not considered as being provided by a health plan within the meaning of the federal tax law such as coverage for accidents, disability, dental care, vision care or preventive care. The Plan will pay or reimburse all medical expenses otherwise allowed by the Plan incurred after the minimum annual deductible is met under the high deductible health plan.

After the limitations in the preceding paragraph are met, the Plan will reimburse eligible expenses. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Care Reimbursement Account. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Health Savings Accounts

In addition, the Plan will establish an HSA Account. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. The balance in the HSA Account may be used to fund a Health Savings Account that is established in your name.

Unlike other Accounts, any balance remaining in your HSA Account at the end of any Plan Year may be carried forward and used to fund such benefits in any subsequent Plan Year. In addition, you may modify your election to contribute the HSA Account at any time as long as the change is effective prospectively (i.e., after the request for the change is received). The Plan Administrator may place additional restrictions on the election of HSA contributions.

Dependent Care Assistance Account

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Assistance Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is \$5,000 (\$2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

Effective January 1, 2011, if you cease to be participant in the cafeteria plan (because of termination of employment or other reason) you may continue to be reimbursed for eligible dependent care expenses through the end of the Plan Year (or grace period if applicable).

You generally must file a Form 2441 to determine whether any part of your Dependent Care Assistance Account is taxable. Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

FORFEITURES

Plan Year/Termination

Any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you terminate employment with the Company will be forfeited after all claims are paid.

Any balance remaining in your HSA Account at the end of any Plan Year will be carried forward and used to fund such benefits in any subsequent Plan Year.

CLAIMS

Deadlines

You must submit claims for reimbursement within 60 days after the end of the Plan Year.

Debit/Credit Cards

The Company will provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your Health Care Reimbursement Account and/or your Dependent Care Assistance Account. The Plan Administrator will provide you with more information about stored value cards at the time you enroll in the Plan.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at

least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to BCI Administrators, Inc. at PO Box 250878, W. Bloomfield, MI 48325-0878. The telephone number is (248) 626-8896.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits.

You may elect to continue coverage on a pre-tax or after tax basis for non medical benefits when on leave of absence under the FMLA.

Non FMLA Leave

In addition, you may elect to continue coverage on a pre-tax or after tax basis when on leave of absence **other** than the FMLA.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is City of Novi.
Its address is 45175 West Ten Mile Rd, Novi, Michigan 48375.
Its telephone number is 248-347-0452.
Its Employer Identification Number is 386032551.
2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number 501.
3. The Plan's designated agent for service of legal process is the chief officer of the entity named in paragraph 1. Any legal papers should be delivered to him or her at the address listed in paragraph 1. However, service may also be made upon the Plan Administrator.
4. The Company's fiscal year ends on June 30 and the plan year ends on December 31.

V3.00-3.00

**CITY OF NOVI
CAFETERIA PLAN
BASIC PLAN DOCUMENT #125**

CITY OF NOVI
CAFETERIA PLAN
BASIC PLAN DOCUMENT
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ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b) and reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, and reimbursement of certain health saving account expenses.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the City on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the City whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2
DEFINITIONS

"Account" means the balance of a hypothetical account established for each Participant as of the applicable date. "Account" or "Accounts" shall include to the extent provided in the Adoption Agreement, a Premium Conversion Account, a Health Care Reimbursement Account, a Dependent Care Assistance Account, an Health Savings Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Adoption Assistance Account" means the Account established with respect to the Participant's election to have adoption expenses reimbursed by the Plan pursuant to Section 4.04.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"City" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" means the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

"Dependent Care Assistance Account" means the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Section 4.03.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the City, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the City is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the City in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means any individual who is employed by the Employer. The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the City or any other employer required to be aggregated with the City under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993 as amended from time to time.

"Health Care Reimbursement Account" means the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Section 4.02.

"Health Savings Account" means the account established with respect to the Participants election to have medical expenses reimbursed by the Plan pursuant to Section 4.08.

"Contract" means an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. Contract shall not include any product which is advertised, marketed, or offered as long-term care insurance. As of January 1, 2014, "Contract" may not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employee's Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Premium Conversion Account" means the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Section 4.01.

"Section 414(s) Compensation" means compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an eligible Employee, provided that this limit is applied uniformly to all eligible.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the City.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to make benefit elections pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to make benefit elections pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date. Notwithstanding the foregoing, a Participant shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 TRANSFERS

If a change in job classification or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Article 4 (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer; unless otherwise provided in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he shall be eligible to participate as of the first day of the subsequent Plan Year; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 4.07(a). If an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall be eligible to participate on the first entry date following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 TERMINATION AND REHIRES

(a) Participants. If a Participant has a Termination of Employment, such Employee shall cease to be a Participant for purposes of Article 4 as of his Termination of Employment. The Plan Administrator may continue participation for purposes of Article 4.01 until the end of the calendar month coincident with or next following his Termination of Employment or other timeframe according to established Plan Administrator procedures. Unless otherwise provided in the Adoption Agreement, if an individual who has satisfied the applicable eligibility requirements set forth in Article 3 as of his Termination date, and who is subsequently reemployed by the City as an Eligible Employee, shall be treated as a new employee.

(b) Non-Participants. An Eligible Employee who has not satisfied the applicable eligibility requirements set forth in Article 3 on his Termination date, and who is subsequently reemployed by the City as an Eligible Employee, shall be eligible to participate on the first entry date following the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections made pursuant to Article 4.

ARTICLE 4
ACCOUNTS

Section 4.01 PREMIUM CONVERSION ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the City toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account shall not exceed the employee-paid portion of premiums payable under the Contracts specified in the Adoption Agreement. If a Contract is offered in conjunction with a City-sponsored benefit plan, a Participant shall be eligible to make contributions to the Premium Conversion Account with respect to that Contract only if he or she is also eligible to participate in the applicable City-sponsored plan. The Account established under this Section 4.01 is intended to qualify under Code Sections 79 and 106(a) to the extent so indicated in the Adoption Agreement and shall be interpreted in a manner consistent with such Code sections. Elections for Code section 79 coverage shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

(b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the City pursuant to Section 4.09; and will be debited for amounts applied to employee-paid portion of applicable premiums. However, the Plan Administrator will not direct the City to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

(c) Conflicts. In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits Participants are entitled to and the circumstances under which coverage terminates.

Section 4.02 HEALTH CARE REIMBURSEMENT ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Health Care Reimbursement Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the City toward the Health Care Reimbursement Account described in Subsection (b). The amount of such salary reduction contributions to the Health Care Reimbursement Account shall not exceed the maximum annual limit described in the Adoption Agreement. The Account established under this Section 4.02 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

(b) Health Care Reimbursement Account. Each Participant's Health Care Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the City pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Reimbursement Account provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.

(c) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Health Care Reimbursement Account for expenses that are: (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

(1) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, dependents shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, expenses for a child (as defined in section 152(f)(1)) of the Participant may be covered until his or her 26th birthday although the Plan Administrator may extend coverage until the end of the calendar year in which the child turns age 26.

(3) Effective January 1, 2011, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(d) Qualified Reservist Distributions.

(1) If the Plan allows Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his Health Care Reimbursement Account specified in the Adoption Agreement provided that such amount was in existence on or after June 18, 2008. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Participant ordered or called to active duty before June 18, 2008 is eligible for a Qualified Reservist Distribution if the Participant's period of active duty continues after June 18, 2008 and meets the duration requirements of IRS Notice 2008-82. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(2) The Plan shall permit a Participant to submit Health Care Reimbursement Account claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The City shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(3) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 4.03 DEPENDENT CARE ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Dependent Care Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the City toward the Dependent Care Assistance Account described in Subsection (b). The Account established under this Section 4.03 is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Dependent Care Assistance Account. Each Participant's Dependent Care Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the City pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the City to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Dependent Care Assistance Account to the extent that such reimbursement: (i) is incurred in the Plan Year (except as provided in Section

4.05(c), (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) **Dependent Care Expenses.** Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection which are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(3) **Limits.** The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is \$5,000 (\$2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) shall apply in determining earned income.

(d) If the Plan allows Employees that cease to be Participants in the plan to spend down unused Dependent Care Assistance Account expenses, Employees that cease to Participate in the Plan (due to Termination or any other reason) may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or grace period if provided in the Plan) to the extent the claims do not exceed the balance of the Dependent Care Assistance Account.

Section 4.04 ADOPTION ASSISTANCE ACCOUNTS

(a) **In General.** To the extent that the Adoption Agreement authorizes Adoption Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the City toward the Adoption Assistance Account described in Subsection (b). The Account established under this Section 4.04 is intended to qualify as an adoption assistance program under Code Section 137 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) **Adoption Assistance Account.** Each Participant's Adoption Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the City pursuant to Section 4.09; and will be debited for reimbursements described in Subsection (c). However, the Plan Administrator will not direct the City to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance Account.

(c) **Eligible Expenses.**

(1) **In General.** A Participant may be reimbursed from his or her Adoption Assistance Account to the extent that such reimbursement is (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) qualifies as adoption assistance; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) **Adoption Assistance.** Adoption assistance is defined as reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are (i) directly related to the legal adoption of an eligible child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any

surrogate parenting arrangement. An eligible child includes a child under age 18 or a child who is physically or mentally incapable of caring for himself/herself. However, an eligible child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any adoption expense with respect to such adoption is not reimbursable until such adoption becomes final.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed for the Adoption Assistance Account for any Plan Year beginning in a calendar year is the maximum amount permitted by federal tax law for that calendar year. The annual limit shall be reduced for adoption assistance expenses incurred any prior Plan Year.

Section 4.05 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year (or after the grace period if Subsection (c) applies) shall be forfeited and shall remain the property of the City. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the City. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Transfers. Amounts may not be transferred between Accounts.

(c) Grace Period. If the Adoption Agreement provides for a 2-1/2 month grace period, effective for grace periods beginning on or after the date specified in the Adoption Agreement and notwithstanding anything to the contrary in the Plan, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period. The grace period shall commence on the first day of the subsequent Plan Year and shall end on the fifteenth day of the third calendar month of the subsequent Plan Year. Unless otherwise provided in the Adoption Agreement, the grace period shall apply to all Accounts in which the Participant is eligible to Participate. Payment or reimbursement of unused benefits shall be subject to the following terms and conditions:

(1) Same Account. Unused contributions remaining at the end of a Plan Year relating to a particular Account may only be used to reimburse expenses incurred with respect to that Account.

(2) No Cash Out. Unused contributions remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(3) No Carryforward. Any unused contributions remaining at the end of a Plan Year that exceed the expenses for a particular Account that are incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and shall be forfeited.

(4) Construction. This Section 4.05(c) is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

Section 4.06 ELECTIONS

(a) New Participants. The Plan Administrator shall provide, where possible, an election form to a Participant before such Participant meets the eligibility requirements of Article 3. In order to participate in the Plan in the initial Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date as specified by the Plan Administrator. However, any election shall not be effective until a pay period following the later of such Participant's effective date of participation pursuant to Article 3 or the date of the receipt of the election form by the Plan Administrator and shall be limited to the expenses incurred after the effective date of the election.

(b) Continuing Participants. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an election form to each Participant and to each other individual who is expected to become a Participant at the beginning of such Plan Year. In order to participate in the Plan in the applicable Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date specified in the

Adoption Agreement, which date shall be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.

(c) Failure to Return Election Form. The failure of a Participant described in Subsection (a) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of a Participant described in Subsection (b) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election not to participate for the applicable Plan Year unless a default election is otherwise specified in the Adoption Agreement or under Subsection (d).

(d) Premium Conversion Special Election Rules. If elected in the Adoption Agreement, a Participant shall be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefits described in Section 4.01 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. If elected in the Adoption Agreement, a Participant's election for benefits described in Section 4.01 shall be automatically adjusted for any change in the cost of premiums pursuant to the terms of Treas. Reg. 1.125-4.

(e) Form of Elections. All elections shall be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Plan Administrator determines that the Plan is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law unless otherwise specified in the Adoption Agreement. To the extent provided in the Adoption Agreement, the Plan Administrator shall also permit a Participant taking unpaid Non-FMLA leave to continue the benefits specified in the Adoption Agreement. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(g) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

(h) Procedures. A Participant shall make the elections described in this Section in such form and manner as may be prescribed by the Plan Administrator and at such time in advance as the Plan Administrator may require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

Section 4.07 REVOCAION OF ELECTIONS

(a) By Participant. Any election made under this Article 4 shall be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions of the Federal Family and Medical Leave Act or other applicable law and is permitted under Treas. Reg. 1.125-4 and the provisions of the Adoption Agreement. If the Adoption Agreement provides that elections may be modified at any time permitted under Treas. Reg. section 1.125-4, elections may be modified upon the occurrence of any of the following events:

(1) HIPAA Special Enrollment Rights. Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).

(2) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(F) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.

(A) Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(B) Number of Dependents. Events that change a Participant'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 Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4 and Section 3.03, change in employment status resulting in gaining or losing eligibility under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's 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 Participant, spouse, or dependent.

(F) Adoption Assistance. For purposes of adoption assistance provided through Section 4.04 of the Plan, the commencement or termination of an adoption proceeding.

(3) Judgment, Decree, or Order. A Participant may modify an election pursuant 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 ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:

(A) changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or

(B) cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.

(4) Entitlement to Medicare or Medicaid. A Participant may modify an election for benefits attributable to a City-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan shall be granted in the case of loss of coverage under Medicare or Medicaid.

(5) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 4.02, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

(6) FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(b) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and non-discriminatory manner.

(c) Automatic Termination of Election. Any election made under this Section shall automatically terminate on the date specified in Sections 3.02 or 3.03.

(d) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 4.07 and whether the Participant's requested election change is consistent with such event.

Section 4.08 HEALTH SAVINGS ACCOUNTS SPECIAL RULES

(a) In General. Notwithstanding anything in the Plan to the contrary, this Section 4.08 shall apply to the extent that the Adoption Agreement allows the Plan to fund Health Savings Accounts within the meaning of Code section 223 ("HSA Contributions").

(b) HSA Account. The Plan Administrator shall establish an HSA Account to separately account for contributions/payments used to fund Health Savings Accounts. Each Participant's HSA Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the City pursuant to Section 4.09; and will be debited for payments to the applicable Health Savings Account.

(c) No Forfeitures. Any balance remaining in a Participant's HSA Account at the end of any Plan Year shall be carried forward and used to fund such benefits in any subsequent Plan Year.

(d) Benefit Limited to Account Balance. The Plan Administrator shall not direct the City to fund a Health Savings Account to the extent the payment exceeds the balance of a Participant's HSA Account.

(e) Period of Coverage. The mandatory twelve month period of coverage shall not apply to HSA Contributions.

(f) Modifications of Elections. A Participant who elects to make HSA Contributions may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for the change is received). The Plan Administrator may place additional restrictions on the election of HSA Contributions; provided, however, that the same restrictions shall apply to all Participants.

(g) HSA Comparability Rules. Any contribution to an HSA from the Plan shall comply with Treas. Reg. section 54.4980G-5 and any superseding guidance.

Section 4.09 EMPLOYER CONTRIBUTIONS

The City may contribute to the Plan to the extent provided in the Adoption Agreement. Such contributions shall be credited to the applicable Account at such time as determined by the City.

ARTICLE 5
LIMITATIONS ON CONTRIBUTIONS

Section 5.01 NONDISCRIMINATION

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

(a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.

(b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) Health Care Reimbursement Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.02.

(d) Dependent Care Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.03.

(e) Adoption Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.04.

Section 5.02 LIMITATIONS ON CONTRIBUTIONS

(a) Cafeteria Plan. Key employees (within the meaning of Code section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all employees under the Plan.

(b) Dependent Care Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 25% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.03. The average benefits provided under Section 4.03 to Participants who are not highly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees of the City.

(c) Adoption Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 5% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.04.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Contracts. All claims for benefits that are provided under Contracts shall be made by the Participant to the City issuing such contract.

(b) Timing of Claims. Reimbursements and/or payments shall only be made for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the City shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(e) Coordination with HRA. A Participant who is also eligible to participate in a Code section 105 health reimbursement arrangement ("HRA") sponsored by the City shall not be entitled to payment/reimbursement under the Health Care Reimbursement Account for expenses that are reimbursable under both the Health Care Reimbursement Account and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the Health Care Reimbursement Account if before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the Health Care Reimbursement Account have been paid.

(f) Death. If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the City from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the City for any liability the City may incur for making such payments,

including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the City may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.02 and/or Section 4.03 provided that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits under Sections 4.02 and 4.03 without the use of the card.

(j) HSA Coordination. Except as otherwise provided in the Adoption Agreement, benefits under this Plan shall not be coordinated with coverage in a high deductible health plan to facilitate participation in Health Savings Accounts.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not violate ERISA section 503 if the Adoption Agreement indicates the plan is subject to ERISA. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE FOR HEALTH CARE REIMBURSEMENT ACCOUNT

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) This Section 6.02(b) shall apply for any claim for benefits under the Health Care Reimbursement Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (E): (I) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule,

guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (II) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) **Appeal of Denied Claim.** If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

(4) **Denial of Appeal.** If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) **Exhaustion of Remedies.** Before a suit can be filed in federal court, claims must exhaust internal remedies.

(c) **Additional Internal and External Claims Procedure for Health Care Reimbursement Account.**

(1) **Applicability.** This Section shall apply for any claim for benefits under the Health Care Reimbursement Account if (A) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (B) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Effective Date. This Section shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(3) Internal Claims Process. The requirements under Section 6.02(b) shall apply as the internal appeals process except as modified below. This section is intended to satisfy the requirements of DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(C) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(D) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(2) External Claims Process.

(A) State External Claims Process. If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act then the plan must comply with the applicable State claims review process.

(B) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (c)(2)(A) above is not applicable.

(d) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. section 54.9801-2 or the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or City and any other applicable law.

Section 6.03 CLAIMS PROCEDURES FOR NON-HEALTH BENEFITS

(a) This Section 6.03 shall apply for any claim for benefits under Accounts other than the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) **Content of Notice of Denied Claim.** If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(d) **Appeal of Denied Claim.** If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

(e) **Denial of Appeal.** If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(f) **Notwithstanding anything to the contrary, if the Adoption Agreement specifies that the Plan is not subject to ERISA, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or City and any other applicable law.**

Section 6.04 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the City from further liability on account thereof.

Section 6.05 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA (if the Adoption Agreement provides that the Plan is subject to ERISA), and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the City.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the City shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Adoption Agreement provides the Plan is subject to ERISA.

Section 7.03 HIPAA PRIVACY RULES

(a) Application. This Section 7.03 shall only apply in the event that this Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy rules.

(b) Privacy Policy. The Plan shall adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.

(c) Business Associate Agreement. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.

(d) Notice of Privacy Practices. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.

(e) Disclosure to the City.

(1) In General. This Subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the City to the extent that such PHI is necessary for the City to carry out its administrative functions related to the Plan.

(2) Permitted Disclosure. The Plan may disclose the PHI to the City that is necessary for the City to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The City may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Subsection.

(3) Limitations. The City agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

(A) Use and Further Disclosure. The City shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Plan, the City shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(B) Agents and Subcontractors. The City shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the City with respect to such information.

(C) Employment-Related Actions. Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the City shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the City.

(D) Reporting of Improper Use or Disclosure. The City shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(E) Adequate Protection. The City shall provide adequate protection of PHI and separation between the Plan and the City by: (i) ensuring that only those employees who work in the human resources department of the City on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the City on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and (iv) using the City's established disciplinary procedures to resolve issues of noncompliance by the employees identified in clause (i) above.

(F) Return or Destruction of PHI. If feasible, the City shall return or destroy all PHI received from the Plan that the City maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the City shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(G) Participant Rights. The City shall provide Participants with the following rights: (i) the right to access to their PHI in accordance with 45 C.F.R. §164.524; (ii) the right to amend their PHI upon request (or the City will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. §164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

(H) Cooperation with HHS. The City shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

(4) Certification. By executing the acCitying Adoption Agreement, the City hereby certifies that the Plan documents have been amended in accordance with 45 C.F.R. §164.504(f), and that the City shall protect the PHI as described in Subsection 3 herein.

(5) Security Standards Requirement. To comply with the Security Standards regulations that were published on February 21, 2003, the City must:

(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 Plan;

(B) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(C) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(D) report to the Plan any security incident of which it becomes aware.

(6) Amendment. Notwithstanding any other provision of the Plan, this Section may be amended in any way and at any time by the Privacy Officer.

(7) Effective Dates. Subsections (1) – (4) and Subsection (6) apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Section (5) applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

Section 7.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

If the plan is not subject to ERISA any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 7.05 HIPAA PORTABILITY RULES

In the event the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. Seq. The Plan Administrator shall only provide a certificate of creditable coverage if the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the City reserves the right to terminate its participation in this Plan. Each such entity constituting the City shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the City, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the City.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the City and the Participant, or as a right of any Employee to continue in the employment of the City, or as a limitation of the right of the City to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the City to provide benefits hereunder shall remain part of the general assets of the City and all payments of benefits under the Plan shall be made solely out of the general assets of the City.

(b) The City shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the City may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The City does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

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

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.