ATTACHMENT A

CITY OF SAN DIEGO

FLEXIBLE BENEFITS PLAN

Amended and Restated as of
July 1, 2023

City of San Diego Flexible Benefits Plan

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INTRODUCTION

The City of San Diego (the "Employer") previously established the City of San Diego Flexible Benefits Plan (the "Plan"). The purpose of the Plan is to provide eligible employees a choice between certain taxable and nontaxable benefits offered under this and other plans maintained by the Employer. The Employer now amends and restates the Plan in its entirety, effective July 1, 2023.

The Plan is intended to qualify as a cafeteria plan under section 125 of the Internal Revenue Code of 1986 and is to be interpreted in a manner consistent with the requirements of that section as it may be amended from time to time.

ARTICLE I

Definitions

Definitions. The following words and phrases have the following meanings unless a different meaning is plainly required by the context.

1.1 "Benefit Option" means a qualified benefit under Code section 125(f) that is offered to a Participant under a Component Plan as described in Appendix A, including any separate options for coverage under an underlying accident or health plan.

1.2 "Change in Status" means any of the following events:

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

(b) An event that changes the number of a Participant's Dependents, including birth, adoption, placement for adoption (as defined in regulations under section 9801 of the Code), or death of a Dependent;

(c) Any of the following events that change the employment status of a Participant, or the Participant's Spouse or Dependents:

(i) a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence or a change in worksite; or

(ii) any other change in employment status that affects the individual's eligibility for benefits under a plan;

(d) An event that causes a Participant's Dependent to satisfy or cease to satisfy the Dependent eligibility requirements under the relevant Component Plan; or

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

1.3 "City" means the City of San Diego.

1.4 "City Council" means the elected legislative body of the City of San Diego.

1.5 "Claims Administrator" means the Plan Administrator, or a third party designated by the Plan Administrator to determine claims for benefits under the Plan.

1.6 "COBRA" means the continuation coverage provisions under sections 2201 through 2208 of the Public Health Service Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and any applicable regulations, rulings, notices or other guidance, as amended.

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

1.8 "Compensation" means the total cash remuneration (including payments for vacation, sick pay and short-term disability, but not long-term disability) received by the Participant from the Employer during a Plan Year, before any reductions under a Salary Reduction Agreement or other Employer-sponsored plan under this Plan.

1.9 "Component Plan" means the plans maintained by the Employer that are listed in Appendix A:

(a) the Premium Payment Component described in Article VI;

(b) the Health Care Spending Account described in Article VII;

(c) the Dependent Care Spending Account described in Article VIII;

(d) The City of San Diego 401(k) Plan; and

(e) Basic Term Life Insurance.

1.10 "Dependent" means (a) for purposes of accident or health coverage offered under a Component Plan and the HCSA, a Participant's dependent as defined in section 152 of the Code, without regard to subsections (b)(1), (b)(2) and (d)(1)(B), child (as defined in section 152(f)(1)) who has not reached age 27 by the end of the applicable Plan Year, or child to whom Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCSA, a Qualifying Individual.

1.11 "Dependent Care Spending Account" or "DCSA" means the Component Plan described in Article VIII.

1.12 "Election Change" means the revocation of an Participant's election under the Plan and making of a new election for the remainder of the Plan Year.

1.13 "Election Form" means the enrollment form or other enrollment process (including telephonic or electronic enrollment) authorized by the Plan Administrator through which an Eligible Employee elects his or her benefits under the Plan, and by which the Eligible Employee agrees to make Salary Reduction Contributions to obtain certain benefits.

1.14 "Eligibility Date" means the date the Employee becomes eligible for benefits, which is the later of the first day of the first pay period in which the Employee works at least 40 hours as an Eligible Employee, or the date the Employee becomes an Eligible Employee.

1.15 "Eligible Employee" means an Employee who is eligible to participate in one or more of the Component Plans. "Eligible Employee" excludes hourly (non-standard hours) Employees, except for hourly Employees the City has determined meet the definition of "full-time employee" under 26 USCA section 4980H(c)(4)(A) and related regulations and IRS guidance.

1.16 "Employee" means any person classified by the Employer as a common law employee. "Employee" does not include any person classified in the Employer's records as an

independent contractor, agent, leased employee, contract employee, temporary employee, or in any other classification other than common law employee, regardless of any determination by a governmental agency or court that the person is a common law employee of the Employer.

1.17 "Employee After-Tax Contributions" means the after-tax contributions made by a Participant to purchase coverage offered under one or more Component Plans, as d23escribed in section 4.3.

1.18 "Employer" means the City.

1.19 "FMLA Leave" means an approved leave of absence protected by the Family and Medical Leave Act of 1993, as amended from time to time.

1.20 "Grace Period" means with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year, during which Medical Care Expenses and Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year.

1.21 "Health Care Spending Account" or "HCSA" means the Component Plan described in Article VII.

1.22 "Health Plan(s)" means the plan(s) described in Appendix A that the Employer maintains for its Employees and their eligible dependents, which provide medical, dental or vision care benefits through a group insurance policy or policies, including any insured plan offering benefits through a health maintenance organization.

1.23 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

1.24 "Military Leave" means a leave of absence protected by USERRA.

1.25 "Non-elective Employer Contributions" means the contributions described in section 4.2 of the Plan.

1.26 "Participant" means an Eligible Employee who is participating in this Plan under Article II.

1.27 "Plan" means this City of San Diego Flexible Benefits Plan.

1.28 "Plan Administrator" means the Employer or any person appointed by the Employer to administer the Plan as set forth in Article X.

1.29 "Plan Year" means the 12-month period beginning each January 1 and ending on the following December 31.

1.30 "PHSA" means the Public Health Service Act, as amended from time to time.

1.31 "Premium Payment Component" means the Component Plan described in Article VI.

1.32 "Qualifying Individual" means (a) a tax dependent of the Participant as defined in Code section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code section 152(a)(1), (b) a tax dependent of the Participant as defined in Code section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year, or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the preceding sentence, in the case of divorced or separated parents, a Qualifying Individual who is a child will, as provided in Code section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)) and will not be treated as a Qualifying Individual with respect to the noncustodial parent.

1.33 "Salary Reduction Contributions" means the contributions described in section 4.1 of the Plan.

1.34 "Similar Coverage" means coverage for the same category of benefits for the same individuals.

1.35 "Spouse" means, except as otherwise provided in this section, the individual who is legally married to a Participant under the laws of the state in which the marriage took place. "Spouse" excludes an individual who has entered into a registered domestic partnership, civil union, or other similar formal relationship with a Participant under the laws of a jurisdiction that is not denominated as marriage under those laws. Solely for purposes of the DCSA, "Spouse" excludes (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains as his or her home a household constituting for more than half of the taxable year the principal abode of a Qualifying Individual, furnishes more than half of the cost of maintaining that household during that taxable year, and whose spouse is not a member of his or her household during the last six months of that taxable year.

1.36 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE II

Participation

2.1 Effective Date of Participation

An Eligible Employee becomes a Participant on his or her Eligibility Date. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment and restatement will continue to be eligible to participate in the Plan. No individual who is not an Eligible Employee may participate in the Plan.

2.2 Termination of Participation

A Participant ceases to be a Participant upon the earliest of the following events:

(a) the date this Plan terminates;

(b) the date the Participant ceases to be an Eligible Employee; or

(c) the date that the Plan is either terminated or amended by the Employer to exclude the Participant or the class of Employees to which the Participant belongs.

Termination of participation in this Plan will automatically revoke the Participant's elections. Benefits under any group insurance plan will terminate as of the date(s) specified in the group insurance plan. Reimbursements from the HCSA and DCSA after termination of participation will be made pursuant to section 7.13 and section 8.13 respectively. If revocation occurs under this section, no new election may be made by the Participant during the remainder of the Plan Year unless otherwise permitted under the Plan.

2.3 Termination of Benefit Option Coverage

(a) A Participant's coverage under any Benefit Option elected under this Plan terminates on the earlier of:

(i) the date specified in the plan document of the Component Plan or in Article VI, VII, or VIII of this Plan; or

(ii) the end of each Plan Year.

(b) A Participant may obtain coverage for subsequent Plan Years only in accordance with the election procedures in section 3.3.

(c) Notwithstanding anything to the contrary in this section, a former Participant or other qualified beneficiary (as defined in section 2208(3) of the PHSA), or a former Participant who is on a Military Leave, may elect to continue coverage under a Component Plan that is a Health Plan beyond the date that coverage would otherwise terminate. The terms and conditions of that continued coverage are set out in the Component Plan's plan document. The Contributions to maintain continuation of coverage must be made directly to the Plan Administrator or insurance carrier as applicable and may not be made under this Plan, except as

otherwise provided in this Plan.

2.4 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired or becomes eligible once again within the same Plan Year, then the Employee will be reinstated with the same elections that such individual had before termination. Unless the Participant has a Change in Status, he or she will not be permitted to change his or her elections until the next open enrollment period. If a former Participant is rehired in a different Plan Year following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. Notwithstanding the preceding sentences of this section, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the applicable group insurance plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee may participate in the Plan by making a timely election to participate in accordance with Article III.

2.5 FMLA Leaves of Absence

(a) Health Insurance Benefits.

(i) Notwithstanding any provision to the contrary in this Plan, if a Participant goes on FMLA Leave, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health insurance benefits and HCSA benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the contributions for those benefits under this Plan.

(ii) The Employer may require Participants to continue all health insurance benefits and HCSA benefits coverage while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the contributions will be paid by the method normally used during any paid leave (e.g., on a pre-tax salary reduction basis).

(iii) In the event of unpaid FMLA Leave (or paid FMLA Leave where the Employer does not require coverage to be continued), a Participant may elect to continue his or her health insurance benefits or HCSA benefits during the leave. If a Participant elects to continue his or her health

insurance benefits or HCSA benefits during the leave, then the Participant may pay his or her share of the contributions using one of the methods described in section 4.5.

(iv) If the Employer requires all Participants to continue health insurance benefits and HCSA benefits during an unpaid FMLA Leave, then the Participant may elect to discontinue payment of the Participant's required contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the contributions not paid by the Participant during the leave as described in section 4.5.

(v) The Participant's right to maintain this coverage terminates when:

(A) the Participant terminates employment by either notifying the Employer that he or she does not intend to return from FMLA Leave or by failing to return from FMLA Leave when that leave is exhausted;

(B) the Participant's employment would have terminated and coverage would have been lost even if he or she had not taken FMLA Leave, as the result of a layoff or downsizing by the Employer; or

(C) the Participant fails to make a required contribution for coverage within the later of 30 days of the date due, or 15 days after the Employer notifies the Employee that his or her coverage will end for failure to make a required contribution. Coverage will end on the last day of the period for which the last contribution was made.

Participant contributions for continuing coverage under the HCSA must be made in accordance with section 4.5.

(vi) If a Participant's health insurance benefits or HCSA benefits coverage ceases while on FMLA Leave (e.g., for non-payment of required contributions or because the Participant revoked his or her health insurance benefit or HCSA coverage election pursuant to section 3.7), the Participant is permitted to re-enter the Premium Payment Component or HCSA, as applicable, upon return from that leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health insurance benefits or HCSA coverage terminated during the leave to be reinstated in that coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA Leave are required to be reinstated in that coverage. Notwithstanding the preceding sentences of this paragraph, a Participant whose HCSA benefits coverage ceased will be permitted to elect to resume that coverage either:

(A) at the same coverage level as was in effect immediately prior to his or her FMLA Leave (making up any contributions that were not

made during the FMLA Leave with increased contributions for the remainder of the Plan Year); or

(B) at a coverage level that is reduced pro rata basis for the FMLA Leave period during which the Participant did not pay contributions, with contributions payable in the same monthly amount as was in effect immediately before the FMLA Leave.

In both instances, the coverage level will be reduced by prior reimbursements.

(vii) A Participant whose HCSA coverage ceased will not be reimbursed for Medical Care Expenses incurred while HCSA coverage was not in effect.

(b) Non-Health Benefits. If a Participant goes on an FMLA Leave, then entitlement to non-health benefits (such as DCSA benefits) will be determined by the Employer's policy for providing such benefits when the Participant is on non-FMLA Leave, as described in section 2.6. If that policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

2.6 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the contributions due for the Participant will be paid using one of the methods described in section 4.4. If a Participant goes on an unpaid leave that affects eligibility, then the applicable Election Change rules in section 3.7 will apply.

ARTICLE III

Election of Benefits

3.1 Benefit Elections

Subject to all other provisions of this Plan, a Participant may choose between receiving his or her full Compensation and receiving coverage under one or more of the Benefit Options provided under the Component Plans listed in Appendix A. Enrollment in any of the Component Plans is governed by the terms and conditions of that Component Plan's plan document.

No benefits under the Plan may be provided in the form of deferred compensation, except that, in accordance with Code section 125 and the Treasury regulations under that section, a Participant may elect to defer cash Compensation available under this Plan into an Employer-sponsored retirement plan that is qualified under Code section 401(a) and contains a cash or deferred arrangement under Code section 401(k) (i.e., a 401(k) plan), but only to the extent permitted under the terms of that retirement plan. The actual terms and conditions of any the 401(k) plan will be contained in a separate, written document.

3.2 Election Procedures Upon Initial Eligibility

(a) General Initial Election Procedures

When an individual becomes an Eligible Employee, the Plan Administrator will provide the Employee an Election Form or other enrollment method, on which the Eligible Employee will: (a) elect his or her Benefit Options for the Plan Year, and (b) agree to make Salary Reduction Contributions as provided in Article IV. If the Eligible Employee enrolls within the 31 days after his or her Eligibility Date, the Employee's coverage under his or her selected Benefit Options will begin on his or her Eligibility Date.

(b) Premium Payment Component and Group-Term Life Insurance Special Initial Election Procedures

Notwithstanding the subsection (a) of this section, an Eligible Employee who has not elected, within 31 days after his or her Eligibility Date, to either (1) enroll in a Health Plan, or (2) waive medical coverage, will automatically be enrolled on his or her Eligibility Date in the lowest-cost Health Plan for employee-only coverage, as identified in the Election Form, for the Plan Year. An Eligible Employee will automatically be enrolled in Basic Term Life Insurance for the Plan Year. The Eligible Employee will be deemed to have elected coverage under these Benefit Options and to make the Salary Reduction Contributions required to pay the cost of that coverage for the Plan Year.

3.3 Annual Enrollment Procedures

(a) General Annual Enrollment Procedures

Before the beginning of each Plan Year, during open enrollment the Plan Administrator will require each Eligible Employee to elect the Benefit Options he or she desires to enroll in for the Plan Year, and agree to make Salary Reduction Contributions as provided in Article IV. Elections are effective on the first day of the Plan Year. Each election must be completed in accordance with all Plan rules on or before the date specified by the Plan Administrator, which will be no later than the beginning of the first pay period of the Plan Year to which the election applies.

(b) Premium Payment Component and Group-Term Life Insurance Special Annual Enrollment Procedures

Notwithstanding the subsection (a) of this section, a Participant who has not elected before the beginning of the Plan Year to either (1) enroll in a Health Plan, or (2) waive medical coverage, will automatically continue to be enrolled for the Plan Year in the lowest-cost Health Plan for employee-only coverage, as identified in the Election Form, for the Plan Year. A Participant will automatically continue to be enrolled in Basic Term Life Insurance for the Plan Year. The Participant will be deemed to have elected coverage under these Benefit Options and to make the Salary Reduction Contributions required to pay the cost of that coverage for the Plan Year.

3.4 Failure to Complete Election Process

(a) Except as provided in section 3.2(b), an Eligible Employee who fails to complete the election process within 31 days of his or her Eligibility Date will be deemed to have elected to receive his or her full Compensation in cash and to have elected no nontaxable Benefit Option (except to the extent of any Non-elective Employer Contributions).

(b) A Participant who fails to complete the election process for any subsequent Plan Year will be deemed to have: (1) elected to continue the Benefit Options he or she elected in the most recent election on file with the Plan Administrator (or the Benefit Options he or she is deemed to have elected under section 3.2(b) or 3.3(b)); and (2) agreed to have his or her Compensation reduced by whatever amount is then necessary to purchase those Benefit Options.

(c) If a Benefit Option in which a Participant was enrolled is eliminated for the subsequent Plan Year, the Plan Administration may enroll the Participant in a Benefit Option providing Similar Coverage, if available, as determined by the Plan Administrator. All similarly-situated Participants will be enrolled in the same Benefit Option

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3.5 Duration of Elections

A Participant's election is irrevocable and remains in effect through the last day of the Plan Year except as provided in section 3.7 or in the applicable Component Plan.

3.6 Reduction or Revocation of Certain Elections by Plan Administrator

The Plan Administrator may reduce a Participant's Salary Reduction Contributions and Non-elective Employer Contributions under this Plan at any time before or during a Plan Year to the extent necessary or advisable to avoid prohibited discrimination, possible taxation of benefits under the Plan that would not otherwise be taxed to any class of Participants for the Plan Year, or loss of the qualified status of benefits received under the Plan under section 79, 125(b), 105(h)(2), or 129(d)(2) of the Code. If the Plan Administrator decides to reduce Salary Reduction Contributions or Employer Non-elective Contributions under this section, the Plan Administrator will do so in the following manner.

(a) If a reduction under this section affects health benefits, the Plan Administrator may reduce the elections of only those Participants who are highly compensated individuals or highly compensated participants, as defined in either section 105(h) or section 125(e) of the Code.

(b) If a reduction under this section affects other qualified benefits, the Plan Administrator may reduce the elections of only those Participants who are highly compensated individuals or highly compensated participants, as defined in section 125(e) of the Code, or who are key employees as defined in section 125(b) of the Code.

(c) If a reduction under this section affects dependent care assistance benefits under section 129 of the Code, the Plan Administrator may reduce the elections of only those Participants who are highly compensated employees, as defined in section 129(d) of the Code, or their Dependents.

(d) The Salary Reduction Contributions or Employer Non-elective Contributions of the affected Participant (a highly compensated individual, highly compensated participant, highly compensated employee or key employee, whichever is applicable) who has the highest amount of Salary Reduction Contributions or Employer Non-elective Contributions for the Plan Year will be reduced until all applicable nondiscrimination tests are satisfied or until the amount of his or her Salary Reduction Contributions or Employer Non-elective Contributions equals the amount of the Salary Reduction Contributions or Employer Non-elective Contributions of the affected Participant who has the second highest amount of Salary Reduction Contributions or Employer Non-elective Contributions. This process will continue until all applicable nondiscrimination tests are satisfied.

3.7 Changes in Employee Elections

A Participant may make an Election Change during a Plan Year only as described below, and only upon the occurrence of the stated events for the applicable Component Plan.

(a) Open Enrollment Period. A Participant may make an Election Change during the open enrollment period in accordance with section 3.3.

(b) Termination of Employment. A Participant's election will automatically terminate under the Plan upon a termination of employment under section 2.2.

(c) Special Enrollment Rights (Applies to Premium Payment Component Benefits Under Group Insurance Plans for Health Benefits Only and Not to Any Other Group Insurance Plan, HCSA or DCSA). A Participant or his or her Spouse or Dependent who is entitled to special enrollment rights under a group health plan (other than an excepted benefit) under section 2704(f) of the PHSA may make an Election Change with respect to that group health plan (or, when required by that section, an election to enroll in another group health plan) that corresponds with those special enrollment rights. In the case of a Participant or his or her Spouse or Dependent who is entitled to special enrollment rights under section 2704(f)(1) or (2) of the PHSA, the Election Change must be made within 30 days of the event giving rise to the special enrollment rights. In the case of a Participant or his or her Spouse or Dependent who is entitled to special enrollment rights under section 2704(f)(3) of the PHSA, the Election Change must be made within 60 days after (1) the Participant's, or his or her Spouse's or Dependent's, Medicaid or state children's health insurance program ("CHIP") coverage terminates, or (2) the Participant or his or her Spouse or Dependent is determined to be eligible for a Medicaid or CHIP premium-assistance subsidy for qualified employer-sponsored health coverage.

(d) Changes in Status (Applies to Premium Payment Component Benefits, HCSA Benefits, and DCSA Benefits)

(i) A Participant may make an Election Change upon the occurrence of a Change in Status, but only if that Election Change is made:

(A) on account of and corresponds with a Change in Status that affects eligibility for coverage either under an Employer's plan or a plan of the Spouse's or Dependent's employer; and

(B) is made within 30 days of the Change in Status.

(ii) A Change in Status that affects eligibility for coverage under an Employer's plan or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in a change in the number of a Participant's family members who may benefit from the coverage. An Election Change also satisfies the requirements of section 3.7(d)(i)(A) if the Election Change is on account of and corresponds with a Change in Status that affects expenses described in section 129 of the Code (including employment-related

expenses as defined in section 21(b)(2) of the Code) with respect to dependent care assistance.

(iii) Special Consistency Rules

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine, based on prevailing IRS guidance, whether a requested Election Change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested Election Change must also satisfy the following specific consistency requirements in order for a Participant to be able to make an Election Change based on the specified Change in Status:

(A) Gain of Coverage Eligibility Under Another Employer's Plan. A Participant may make an Election Change to cancel or decrease the coverage of the Participant or his or her Spouse or Dependent who becomes eligible for coverage under a cafeteria plan or qualified benefit plan of the employer of a Participant's Spouse or Dependent because of a change in marital or employment status only if the individual actually enrolls for that newly available coverage. The Plan Administrator may rely on the Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect. If a Participant has a Change in Status involving the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to be eligible for coverage, the Participant may not make an Election Change to cancel coverage for any individual other than the affected Spouse or Dependent.

(B) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the preceding sentences, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a

Participant under this Plan), then the Participant may increase his or her election to pay for such coverage.

(C) Special Consistency Rule for DCSA. With respect to the DCSA benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) the change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the Election Change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion under Code section 129.

(D) Life Insurance, AD&D and Disability Coverage. An Election Change to either increase or decrease coverage under a group-term life insurance, accidental death and dismemberment insurance, or disability insurance due to a Change in Status is deemed to correspond with the Change in Status.

(E) Reemployment Within the Same Plan Year. If a Participant terminates and resumes City employment within the same Plan Year, without an intervening Change in Status that would otherwise permit an Election Change under this section, he or she may not make an Election Change. Instead, the Participant's elections in effect when he or she terminated will be reinstated.

(e) Public Health Marketplace Related Events (Applies to Premium Payment Components Benefits only).

(i) A Participant may revoke his or her election with respect to the Health Plans listed in Appendix A in the following circumstances and in accordance with IRS Notice 2014-55 and any subsequent guidance related thereto:

(A) Reduction in Hours Not Causing Loss of Eligibility. A Participant who has been in an employment status under which he or she was reasonably expected to average at least 30 hours of service per week and there is a change in status so that a Participant will reasonably be expected to average less than 30 hours of service per week after the change, even though that reduction does not result in you ceasing to be eligible under the Health Plans. A Participant's revocation must correspond with the intended enrollment of the Participant (and any related Dependents who cease coverage due to the Participant's revocation) in another plan that provides minimum essential coverage with the new coverage being effective no later than the first day of the second month following the month that includes the date the Participant's election was revoked.

(B) Eligibility for Public Health Marketplace Coverage. A Participant becomes eligible to enroll for coverage in a public health marketplace during a marketplace special or annual open enrollment period. A Participant's revocation must correspond to the intended enrollment of the Participant (and any related Dependents who cease coverage due to the Participant's revocation) in a qualified health plan through a public health marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(ii) In addition to the foregoing restrictions, the ability to make an election change in accordance with this section applies only to a medical plan that is both "affordable" and provides "minimum value" pursuant to Code Section 4980H and the guidance thereunder.

This subparagraph (e) is effective for Plan Years beginning on or after July 1, 2017.

(f) Changes in Cost (Applies to Premium Payment Component Benefits, DCSA Benefits as Limited Below, but Not to HCSA Benefits)

(i) Insignificant Cost Changes. Participants are required to increase their Salary Reduction Contributions to reflect insignificant increases in their required contribution for their Benefit Plan Option(s), and to decrease their Salary Reduction Contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all of the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Participants' Salary Reduction Contributions on a prospective basis.

(ii) Significant Cost Changes

(A) If the Plan Administrator determines that a Participant's Benefit Option cost increases significantly during a Plan Year, the Participant may:

(1) make a corresponding prospective increase in his or her Salary Reduction Contributions;

(2) revoke his or her election for that Benefit Option for the balance of the Plan Year and, instead, elect prospectively a Benefit Option that provides Similar Coverage; or

(3) drop coverage prospectively if there is no other Benefit Option that provides Similar Coverage.

To be effective, an Election Change must be made within 31 days after the cost increase. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant under prevailing IRS guidance.

(B) If the Plan Administrator determines that a Benefit Option's cost decreases significantly during a Plan Year, the Plan Administrator may allow:

(1) a Participant enrolled in that Benefit Option to make a corresponding prospective decrease in his or her Salary Reduction Contributions;

(2) all Participants, including those who did not enroll in the Benefit Option, to revoke their elections for the balance of the Plan Year, and elect the Benefit Option that decreased in cost for the balance of the Plan Year; or

(3) Participants who enrolled in a different Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and elect the Benefit Option that decreased in cost for the balance of the Plan Year.

To be effective, an Election Change must be made within 31 days after the cost decrease. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant under prevailing IRS guidance.

(C) The preceding cost-change provisions apply to the DCSA only if the cost change is imposed by a dependent care provider who is not a "relative" of the Participant. For this purpose, a relative is an individual who is related as described in Code section 152(d)(2)(A)-(G), incorporating the rules of Code section 152(f)(1). To be effective, an Election Change must be made within 31 days of the cost change.

(iii) Notwithstanding anything to the contrary, this subsection does not apply to an Election Change with respect to the HCSA or on account of a change in cost or coverage under an HCSA.

(g) <u>Coverage Changes (Applies to Premium Payment and DCSA Benefits, but Not to HCSA Benefits)</u>

(i) <u>Addition or Significant Improvement of a Benefit Option</u>. If the Plan adds a new Benefit Option or significantly improves an existing Benefit Option during a Plan Year, the Plan Administrator may allow:

(A) all Participants (including those who had not previously elected coverage under a Benefit Option providing Similar Coverage) to revoke their elections for the balance of the Plan Year and prospectively elect the new or significantly improved Benefit Option; or

(B) only those Participants who are enrolled in another Benefit Option providing Similar Coverage to revoke their elections for the balance of the Plan Year and prospectively elect the new or significantly improved Benefit Option.

To be effective, an Election Change must be made within 31 days after the addition or significant improvement. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether the Plan has added a new Benefit Option or significantly improved an existing Benefit Option under prevailing IRS guidance.

(ii) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Option coverage (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, resulting in a loss of coverage during a Plan Year, the Participant may:

(A) revoke his or her Benefit Option election and prospectively elect another Benefit Option that provides Similar Coverage; or

(B) drop coverage if no other Benefit Option provides Similar Coverage.

For this purpose, a "loss of coverage" means a complete loss of coverage under a Benefit Option, including the elimination of the Benefit Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or the loss of all coverage under the Benefit Option by reason of a lifetime or annual limitation. In addition, the Plan Administrator, in its sole discretion and on a uniform and consistent basis, may treat the following as a loss of coverage:

(A) a substantial decrease in the medical care providers available under the Benefit Option (such as the withdrawal of a major hospital from a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or HMO);

(B) a reduction in the benefits for a specific type of medical condition for which an employee or dependent is currently in a course of treatment; or

(C) any other similar fundamental loss of coverage.

To be effective, an Election Change must be made within 31 days of the loss of coverage.

(iii) Significant Curtailment Without a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Option coverage (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a loss of coverage during a Plan Year, the Participant may revoke his or her Benefit Option election and prospectively elect another Benefit Option that provides Similar Coverage, but not drop coverage. For this purpose, coverage under a Benefit Option is "significantly curtailed" only if there is an overall reduction in coverage provided under the plan generally, including a significant increase in the deductible, the copayment, or the out-of-pocket cost-sharing limit under an accident or health plan. To be effective, an Election Change must be made within 31 days of the curtailment.

(iv) Changes in Coverage under the DCSA

(A) A Participant may make a prospective Election Change that is on account of and corresponds with the Participant's change in the dependent care provider, even if the new provider is the Participant's household employee, family member, or Dependent. To be effective, an Election Change must be made within 31 days after the new dependent care provider first provides dependent care services.

(B) A Participant may make a prospective Election Change that is on account of and corresponds with a change in the number of hours of work performed by a dependent care provider. To be effective, the Election Change must be made within 31 days after the provider's hours of work are first reduced.

(v) Changes in Coverage under Another Employer's Plan. A Participant may make a prospective Election Change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer) if:

(A) the other cafeteria plan or qualified benefits plan permits an election change permitted under applicable IRS regulations; or

(B) the Plan permits Participants to make an Election Change for a Plan Year that is different from the period of coverage under the cafeteria plan or qualified benefits plan.

To be effective, the Election Change must be made within 31 days of the coverage change under the other plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a

requested change is on account of and corresponds with a change made under the other employer plan under prevailing IRS guidance.

An Election Change is permitted only if it is permitted under the relevant Component Plan. Any Election Change to drop coverage will be effective only as to those individuals who become covered under the other plan.

(vi) Loss of Other Group Health Coverage. A Participant may make a prospective Election Change to add group health coverage for the Participant or his or her Spouse or Dependent, if that individual loses coverage under any group health plan sponsored by a governmental or educational institution, including but not limited to the following:

(A) a state's children's health insurance program under Title XXI of the Social Security Act;

(B) a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;

(C) a state's health benefits risk pool; or

(D) a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

To be effective, the Election Change must be made within 31 days of the loss of coverage.

(vii) No Election Change may be made with respect to the HCSA under this subsection.

(h) Other Permissible Changes

(i) Certain Judgments, Decrees and Orders (Applies to Premium Payment Benefits and HCSA, but Not to DCSA). If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a national medical support order) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), the Participant may make an Election Change to:

(A) provide coverage for the child if the Order requires the Participant to provide coverage; or

(B) revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and that coverage is actually provided.

To be effective, an Election Change must be made within 31 days after the Order is issued to the Participant.

(ii) Medicare and Medicaid (Applies to Premium Payment Component Benefits, HCSA, as Limited Below, but Not to DCSA)

(A) If a Participant or his or her Spouse or Dependent who is enrolled under a Health Plan Benefit Option enrolls in Medicare or Medicaid (other than coverage consisting solely of benefits under section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may make a prospective Election Change to reduce or cancel that individual's coverage under that Benefit Option, or cancel (but not reduce) the Participant's HCSA coverage. Provided, that the cancellation will not become effective to the extent that it would reduce future contributions to the HCSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

(B) If a Participant or his or her Spouse or Dependent who is enrolled in Medicare or Medicaid loses eligibility for that coverage, the Participant may make a prospective Election Change to enroll that individual in, or increase that individual's coverage under, a Health

Plan Benefit Option as otherwise permitted under the terms of the Component Plan, or commence or increase the Participant's HCSA coverage.

To be effective, an Election Change must be made within 31 days of the date the individual enrolls in Medicare or Medicaid as described above or loses eligibility for that coverage, as applicable.

(i) Family and Medical Leave

(i) Except as provided in paragraph (iii) below, a Participant who goes on unpaid FMLA Leave may:

(A) revoke his or her election under a Health Plan Benefit Option at the onset of that leave, or at any time during that leave; and

(B) revoke his or her election with respect to non-health benefits to the same extent as employees who are on unpaid leaves of absence other than FMLA Leave are permitted to revoke their elections.

(ii) Upon return from an FMLA Leave, an Eligible Employee who revoked an election may choose to reinstate that election, provided, however, that the Employer may require reinstatement of the election if the Employer also requires employees who return from unpaid non-FMLA Leave to resume participation under a Benefit Option upon return from leave.

(iii) The Plan will not allow a Participant to revoke his or her election if the Employer continues and pays the full cost of the Participant's coverage while the Participant is on FMLA Leave. The Employer may recover the Participant's share of contributions towards coverage when the Participant returns to work from his or her FMLA Leave.

(iv) A Participant who is on FMLA Leave has the same right to make an Election Change described in sections 3.3 and 3.7(a), (b), (c), (d), (e), (f), and (g) as other employees participating in the Plan who are on non-FMLA Leave.

(j) Change to HCSA Elections. Election Changes may not be made to reduce HCSA coverage during a Plan Year; however, Election Changes may be made to cancel HCSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for HCSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for HCSA coverage. Provided, that any cancellation will not become effective to the extent that it would reduce future contributions to the HCSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

(k) Elective Contributions Under a Cash or Deferred Arrangement. This section does not apply to elective contributions under a qualified cash or deferred arrangement (within the meaning of section 401(k) of the Code) or employee contributions subject to section 401(m) of the Code. Therefore, a Participant may modify or revoke elections under a 401(k) plan only in accordance with sections 401(k) and (m) and the regulations thereunder and the terms of the plan.

(l) Effective Date of Election Changes. An Election Change made under this section that involves the addition of a new Dependent through birth, adoption, or placement for adoption, is effective on the date the change is effective under the relevant Component Plan. An Election Change under this section that does not involve the addition of a new Dependent through birth, adoption, or placement for adoption is effective with the pay period that begins coincident with or immediately following the Plan Administrator's acceptance of the new election, regardless of when coverage becomes effective under the Component Plan. Election Changes related to the Benefit Options described in Articles VII and VIII are effective with the pay period that begins coincident with or immediately following the first day of the calendar month after the Plan Administrator accepts the new Election Change.

ARTICLE IV

Contributions

4.1 Salary Reduction Contributions

A Participant may elect to reduce his or her Compensation for a Plan Year and to use these amounts to purchase one or more benefits offered under the Component Plans. The monetary amount associated with this election constitutes a Salary Reduction Contribution. Except as provided in sections 3.2(b) and 3.3(b), Salary Reduction Contributions must be authorized by the Participant on the Election Form or other enrollment method authorized by the Employer. Salary Reduction Contributions are considered contributions made by the Employer on a Participant's behalf.

As to the benefits described in Articles VII and VIII, the amount of a Participant's Salary Reduction Contributions for the Plan Year is the total coverage amount selected by the Participant for these benefits, subject to the limitations contained in those Articles**.** The amount of the reduction in the Participant's Compensation for the Plan Year for coverage under one or more of the Component Plans listed in Appendix A equals the Participant's share of the cost of that coverage for the Plan Year, as determined by the Employer.

4.2 Non-elective Employer Contributions

The Employer may make Non-elective Employer Contributions on a Participant's behalf for each Plan Year in the amounts determined by the Employer in its discretion. These amounts will be allocated in equal amounts to similarly-situated Participants.

A Participant may elect to waive coverage under the available Benefit Options as defined in the terms of the Component Plans and in Articles VI, VII and VIII. The Employer will pay Non-elective Employer Contributions that the Participant does not allot to Benefit Options in cash in accordance with Plan procedures and the governing Memoranda of Understanding between the City and its recognized employee organizations.

4.3 Employee After-Tax Contributions

Under certain circumstances, a Participant may pay for coverage under certain Benefit Options from Compensation that has been subject to federal income taxes ("Employee After-Tax Contributions"). Employee After-Tax Contributions may be made for the following purposes:

(a) to pay for coverage of a domestic partner or any other individual who may not be treated as the Participant's Dependent under the Code;

(b) to pay for continuation of coverage during an unpaid FMLA Leave as described in section 4.5;

(c) to pay for continuation of coverage under the HCSA as described in section 7.13; or

(d) for such other purposes as determined by the Plan Administrator on a nondiscriminatory basis for all similarly situated Participants.

4.4 Contributions by Participants on Approved Leaves of Absence other than Unpaid FMLA Leave

A Participant who is on an approved leave of absence other than unpaid FMLA Leave, and who is otherwise eligible to continue to receive health insurance benefits and HCSA benefits under this Plan while on leave, must make contributions required to purchase these benefits under the Plan as provided below:

(a) The Compensation of a Participant who is on a paid leave of absence will be reduced in the same manner and in the same amount as if the Participant was not on leave.

(b) A Participant who is on unpaid leave of absence must:

(i) Make direct premium payments to the Employer each pay period. The amount of these payments will be determined in accordance with the Employer's leave of absence policy; or

(ii) Make contributions to the Plan in any other manner that may be agreed to by the Plan Administrator and the Participant.

4.5 Contributions by Participants for Coverage Continued During Unpaid FMLA Leave

(a) Except as provided below, a Participant who elects to continue health insurance and HCSA coverage while on unpaid FMLA Leave must pay his or her share of the cost of this coverage by making direct contributions to the Plan on the same schedule as contributions would be made if the Participant was not on leave, or under any other payment schedule permitted under: (1) 29 CFR § 825.210(c), (2) the Employer's existing rules for payment by Employees on other types of unpaid leave, or (3) under any other system voluntarily agreed to between the Participant and the Employer that is not inconsistent with 26 CFR § 1.125-3 or 29 CFR § 825.210(c).

(b) The Plan Administrator, in its sole discretion, may also permit a Participant to pay for health insurance and HCSA coverage continued during FMLA Leave under either of the following payment methods:

(i) Pre-pay method. Before a Participant begins his or her FMLA Leave, the Participant may pre-pay the amounts necessary to continue coverage during the FMLA Leave period.

(ii) Catch-up method. The Participant may pay for his or her share of the cost to continue coverage during the FMLA Leave after returning from FMLA Leave. This method of payment may be used only if the Employer and the Participant agree, before the FMLA Leave begins, that:

(A) the Participant elects to continue health coverage while on unpaid FMLA Leave;

(B) the Employer assumes responsibility for advancing payment of the premiums on the Participant's behalf during the FMLA Leave; and

(C) these amounts will be paid by the Participant when the Participant returns from FMLA Leave.

(iii) Notwithstanding anything to the contrary in this subsection, the Employer may use the "catch-up" method to recoup the Participant's share of the cost of continued coverage without obtaining the Participant's prior agreement if:

(A) the Employer chose to continue the Participant's coverage during FMLA Leave and the Participant chose to discontinue payment of his or her share of the cost of coverage during the duration of the leave; or

(B) the Participant had previously elected to continue coverage during FMLA Leave, failed to make required payments, and the Employer then elected to continue the coverage.

(c) Basis of Payment. Participant contributions under any method of payment may be made on an after-tax basis. In addition, the Employer may permit a Participant to make contributions on a salary reduction basis as follows:

(i) Contributions may be made on a salary reduction basis under the payment method in section 4.5(a) to the extent the contributions are made from taxable compensation due the Participant during the FMLA Leave period.

(ii) Contributions under the "pre-pay" method (in section 4.5(b)(i)) may be made on a salary reduction basis from any taxable compensation, but if the FMLA Leave period spans two Plan Years, pre-payment on a salary reduction basis may not be made for the FMLA Leave period that falls in the second Plan Year.

(iii) Contributions under the "catch-up" method of payment (in section 4.5(b)(ii)) may be made on a salary reduction basis from any available taxable compensation after the Participant returns from FMLA Leave, as long as the Participant has not made any after-tax contributions towards that coverage.

At the Employer's discretion, taxable compensation may also include compensation attributable to unused sick days or unused vacation days.

(d) The payment methods for Participants on FMLA Leave will not be offered on terms less favorable than those offered to Participants who are not on FMLA Leave.

4.6 Maximum Amount of Contributions

The maximum amount of a Participant's Salary Reduction Contributions for each Plan Year will, when added to any Non-elective Employer Contributions made available by the Employer for the Plan Year, not exceed the aggregate cost of the Benefit Options elected by the Participant for the Plan Year.

The maximum amount of Non-elective Employer Contributions for each Plan Year is the amount determined by the Employer and specified on the Election Form for the Plan Year, which is hereby incorporated into the Plan by reference.

ARTICLE V
Benefits

5.1 Benefit Options

When first eligible or during the open enrollment period as described under Article III, Participants will be given the opportunity to elect one or more of the following Component Plan benefits:

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

(b) Health Care Spending Account benefits, as described in Article VII;

(c) Dependent Care Spending Account benefits, as described in Article VIII;

(d) The City of San Diego 401(k) Plan, as described in that plan's plan document; and

(e) Basic Term Life Insurance.

Notwithstanding the preceding sentence, each Participant is required to enroll in Basic Term Life Insurance. Any Participant who does not either (1) enroll in a Health Plan, or (2) waive Health Plan coverage, will be automatically enrolled in Basic Term Life Insurance. The Eligible Employee will be deemed to have elected coverage under these Benefit Options and any required Salary Reduction Contributions.

ARTICLE VI

Premium Payment Component

6.1 Benefits

Except as provided in sections 3.2(b) and 3.3(b), an Eligible Employee may elect to participate in the Premium Payment Component by electing (a) to receive benefits under the Health Plans described in Appendix A; and (b) to pay for his or her share of the contributions for those benefits with Salary Reduction Contributions or any Employer Non-elective Contributions. Unless an exception applies (as described in section 3.7), the election is irrevocable for the duration of the Plan Year to which it relates. Notwithstanding any other provision in this Plan, insurance benefits under the Health Plans are subject to the terms and conditions of the Health Plans, and no changes can be made with respect to these plans (such as mid-year changes in election) if the changes are not permitted under the applicable Health Plan.

6.2 Participant Contributions for Cost of Coverage

A Participant's annual contribution for his or her share of the cost of the Health Plan Benefit Option elected is the amount established by the Employer, as set forth in the annual enrollment materials.

6.3 Benefits Provided Under the Health Plans

Group insurance benefits will be provided by the Health Plans in accordance with their governing documents, and not this Plan. The types and amounts of insurance benefits, the requirements for participating in the Health Plans, and the other terms and conditions of coverage and benefits of such plans are set forth in their governing documents. All claims to receive benefits under the Health Plans will be subject to and governed by the terms and conditions of the Health Plans and the rules, regulations, policies, and procedures adopted in accordance with those plans, as may be amended from time to time.

6.4 Health Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose health coverage terminates under a Health Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), will be given the opportunity to continue on a self-pay basis the same health coverage that he or she had under the applicable Health Plan the day before the qualifying event for the periods prescribed by COBRA. This continuation coverage will be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage under a Health Plan may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where

COBRA coverage arises because either (a) the Participant ceases to be eligible due to a reduction in hours; or (b) the Participant's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Participants who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for Health Plan benefits will be paid on an after-tax basis (unless as may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII

Health Care Spending Account

7.1 Health Care Spending Account

This Health Care Spending Account (HCSA) is intended to qualify as a nontaxable self-insured medical reimbursement plan under section 105 of the Code, and will be interpreted consistently with the requirements of sections 105 and 125 of the Code and the Treasury regulations issued under those sections. All other provisions of this Plan apply to and govern this HCSA, unless expressly contradicted by any provision of this Article or any applicable law or regulation.

7.2 Health Care Spending Account Benefits

An Eligible Employee may elect to participate in the HCSA by electing to (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the HCSA, and (b) pay for those HCSA benefits with Salary Reduction Contributions and Employer Non-elective Contributions. Unless an exception applies (as described in section 3.7), any such election is irrevocable for the duration of the Plan Year to which it relates.

7.3 Eligible Medical Care Expenses for HCSA

Under the HCSA, a Participant may receive reimbursement for Medical Care Expenses incurred during the Plan Year for which an election is in force. In addition, certain individuals may receive reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their HCSA for that Plan Year in accordance with Section 7.9(c).

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

(b) Medical Care Expenses. "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in section 213(d) of the Code, but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the HCSA can reimburse the remaining portion of the Medical Care Expense if it otherwise meets the requirements of this Article. Medical Care Expenses exclude:

(i) premium payments for other health coverage;

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

(iii) "qualified long-term care services," as defined in Code section 7702B(c); or

(iv) any other expense otherwise excluded under the terms of the Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in these procedures. A list of covered expenses is available from the Administrator.

7.4 Establishment of Health Care Spending Accounts

(a) The Plan Administrator will establish and maintain a HCSA for each Participant for each Plan Year for which the Participant elects to participate in the Health Care Spending Account, but it will not create a separate fund or otherwise segregate assets for this purpose. The account will be merely a recordkeeping account for the purpose of tracking contributions and determining forfeitures under section 7.14.

(b) Subject to section 7.6, a Participant's HCSA for a Plan Year will be periodically credited during the Plan Year with the sum of (i) the Participant's Salary Reduction Contributions, and (ii) any Non-elective Employer Contributions to be allocated to a Participant's HCSA for the Plan Year. A Participant's HCSA for a Plan Year will be debited for any reimbursement of Medical Care Expenses incurred during the Plan Year (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in section 7.9(c)).

(c) The amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year, not the amount credited to the HCSA at a particular point in time. Thus, a Participant's HCSA may have a negative balance during a Plan Year, but the aggregate amount of reimbursement will in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.5 Participant Contributions for Cost of Coverage of HCSA Benefits

The annual contribution for a Participant's HCSA benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in section 7.6.

7.6 Limitations on Contributions

The maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions that a Participant may elect to allocate to his or her HCSA for any Plan Year is the amount stated in the City's annual open enrollment materials. The minimum amount that a Participant may elect to contribute to the HCSA for any Plan Year is $240.

7.7 Timing of Contributions

Except as provided in sections 4.5 and 7.8, Salary Reduction Contributions for the Plan Year must be contributed in substantially equal payments throughout the Plan Year. The number of payments must equal the number of pay periods in the Plan Year (that are expected to occur with respect to an individual Participant), or portion thereof, during which the Employee is a Participant in this Plan. The payments must be made on each pay date while the individual is a Participant. For purposes of this section, the pay periods ending on September 1, 2023 and March 1, 2024 are excluded, meaning that Participants will make their Fiscal Year 2024 Salary Reduction Contributions in only 24 of 26 pay periods.

7.8 Limitation on Election Changes

A Participant may revoke his HCSA election and make a new HCSA election for the remainder of the Plan Year only in accordance with section 3.7. If a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, will apply to Medical Care Expenses incurred after the election is effective. Any change in an election under section 3.7 (other than under section 3.7(h) for FMLA Leave) that increases contributions to the HCSA also will change the maximum reimbursement benefits for the balance of the Plan Year commencing with the Election Change. The maximum reimbursement benefits for the balance of the Plan Year will be the sum of (a) the contributions (if any) made by the Participant as of the end of the portion of the Plan Year immediately preceding the change in election, and (b) the total contributions scheduled to be made by the Participant during the remainder of the Plan Year to the HCSA, reduced by (c) all reimbursements made during the entire Plan Year. Any change in an election under section 3.7(h) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

7.9 Limitations on Benefits

(a) The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Plan Year (reduced by prior reimbursements during the Plan Year) will be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's HCSA pursuant to section 7.4. Notwithstanding the preceding sentence, no reimbursements will

be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA. Payment will be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Plan Year (or related Grace Period that applies to the Participant under subsection (c) of this section) for which the Participant's election is effective, provided that the other requirements of this Article have been satisfied.

(b) Except as otherwise provided in subsection (c) of this section, the HCSA Plan will not reimburse any Participant with respect to any Plan Year for any expense that:

(i) was not a Medical Care Expense;

(ii) was not incurred during the Plan Year;

(iii) was submitted after the earlier of 30 days following the date of termination of employment or the last day of July of the following Plan Year; or

(iv) when taken together with prior reimbursements received by the Participant for that Plan Year, exceeds the amount of the Participant's HCSA election for the Plan Year in effect on the date the expense was incurred.

(c) Grace Periods; Special Rules for Claims Incurred During a Grace Period. Notwithstanding any contrary provision in this Plan and subject to the conditions of this section, an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her HCSA at the end of the Plan Year to which that Grace Period relates if he or she is either: (i) a Participant with HCSA coverage that is in effect on the last day of that Plan Year; or (ii) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the HCSA Component Plan on the last day of that Plan Year.

(i) Prior Plan Year HCSA amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, they may not be used to reimburse Dependent Care Expenses.

(ii) Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Sections 7.10, 7.11 and 7.12 will be reimbursed first from any available prior Plan Year HCSA amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the HCSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from prior Plan Year HCSA amounts if the card is unavailable for such reimbursement. An individual's prior Plan Year HCSA amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such prior Plan Year HCSA amounts.

(iii) Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than March 31 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from prior Plan Year HCSA amounts. Any prior Plan Year HCSA amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in section 7.14.

7.10 Claims for Reimbursement

Claims for reimbursement of Medical Care Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 92 days after the end of the Plan Year, those Medical Care Expense claims shall not be considered for reimbursement by the Claims Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement of Medical Care Expenses must be submitted within 30 days after termination of employment.

7.11 In the event of the Participant's death, the Participant's Spouse (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article in accordance with section 7.13.

Debit and Credit Cards

A Participant may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Care Expenses, subject to the following terms:

(a) Card only for Medical Care Expenses. Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. A Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) Card Issuance. Such card shall be issued upon a Participant's Eligibility Date and reissued for each Plan Year a Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon a Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the HCSA.

(c) Maximum Dollar Amount Available. The dollar amount of coverage available on the card shall be the amount elected by a Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 7.6.

(d) Only Available for Use with Certain Service Providers. The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) Card Use. The cards shall only be used for Medical Care Expense purchases at these providers, including, but not limited to, the following:

(i) Co-payments for doctor and other medical care;

(ii) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(iii) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) Substantiation. Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) Correction Methods. If such purchase is later determined by the Administrator to not qualify as a Medical Care Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(i) Repayment of the improper amount by the Participant;

(ii) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(iii) Claims substitution or offset of future claims until the amount is repaid; and

(iv) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

7.12 Determination of Claims

The Claims Administrator will notify a claimant in writing that his or her claim has been

denied within 30 days after its receipt of the claim or any information requested by the Claims Administrator that is necessary to decide the claim. This period may be extended an additional 15 days for matters beyond the Plan's control, if the Claims Administrator notifies the claimant in writing of the circumstances that require the extension before the initial 30-day period expires.

7.13 Procedures for Appealing a Claim Denial

(a) A claimant has 60 days from the date he or she receives notice of a claim denial to appeal the denial in writing to the Plan Administrator.

(b) The Plan Administrator will notify the claimant of its decision on the appeal no later than 30 days after the Plan Administrator receives the appeal**.** This period may be extended an additional 30 days with advance written notice from the Plan Administrator.

(c) The Plan Administrator's decision is final.

(d) A claimant's Authorized Representative may act on the claimant's behalf at any stage of these claims procedures. Once an Authorized Representative has been appointed, the Plan will direct all information and notices to the Authorized Representative. The Plan will provide the claimant copies of all notifications regarding decisions, unless the claim provides specific written direction otherwise. Any reference to a claimant in these claims procedures is intended to include the claimant's Authorized Representative. For this purpose, "Authorized Representative" means an individual who a claimant has authorized in writing to file and pursue a claim or appeal on the claimant's behalf. An assignment of payment to a health care provider is not the appointment of an Authorized Representative under these claims procedures.

7.14 Reimbursements From HCSA After Termination of Participation; COBRA; USERRA

(a) When a Participant ceases to be a Participant under section 2.2, the Participant's Salary Reduction Contributions and election to participate will terminate on the last day of the pay period for which a required contribution was made. Except as otherwise provided in section 7.9(c) (regarding certain individuals who may be reimbursed from prior Plan Year HCSA amounts for expenses incurred during a Grace Period), the Participant will be reimbursed only for Medical Care Expenses incurred before the Participant's HCSA coverage terminates, and only if a request for reimbursement is made as provided in sections 7.10 and 7.11. No reimbursement will exceed the amount of the Participant's election for the Plan Year on the day the Medical Care Expense was incurred less prior reimbursements for that Plan Year. However, the Participant's Spouse (or if none, the Participant's executor or administrator) may claim reimbursement for any Medical Care Expenses incurred during the Plan Year prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 7.9(c)), provided that the Participant's Spouse(or if none, the Participant's executor or administrator) files a claim within 30 days after the date that the Participant ceases to be a Participant.

(b) Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant or his or her Spouse and Dependents, who is a qualified beneficiary (as defined in section 2208 of the Public Health Service Act ("PHSA")) and whose HCSA coverage terminates because of a COBRA qualifying event (as defined in section 2203 of the PHSA) may elect to continue on a self-pay basis the same coverage that he or she had under the HCSA the day before the qualifying event for the periods prescribed by COBRA.

Specifically, these individuals will be eligible for COBRA continuation coverage only if, under section 7.4, they have a positive HCSA balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). The Plan Administrator will notify these individuals if they are eligible for COBRA continuation coverage. If the individual elects COBRA, it will be available only for the remainder of the Plan Year in which the qualifying event occurs. This COBRA coverage for the HCSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year. This continuation coverage will be subject to all conditions and limitations under COBRA. Notwithstanding the preceding, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the HCSA Component Plan on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year in accordance with the provisions of section 7.9(c).

To continue coverage under COBRA, a Participant must make direct and timely contributions to the Employer. The amount of the contributions may be subject to a surcharge in the sole discretion of the Employer, but will not exceed the maximum permitted under applicable federal law. To the extent required by COBRA, a qualified beneficiary who has elected to continue coverage under COBRA will be treated as a Participant under the Plan. If continuation coverage is elected, coverage will be maintained, and Medical Care Expenses reimbursed, as provided in this Article.

The right of a Participant or other qualified beneficiary to COBRA continuation coverage will terminate on the earlier of the last day of the Plan Year in which the qualifying event occurs, or the date on which one of the events specified in section 2202(2)(B) or (C) of the PHSA (relating to the Employer's ceasing to provide any group health plan to any Employee or the Participant's failure to make timely premium payments under the Plan) occurs.

(c) A Participant who is on a Military Leave may elect to continue his or her coverage under the HCSA Benefit Option beyond the date that coverage would otherwise terminate by making direct and timely contributions to the Employer for the period during which coverage is required to be maintained under USERRA. Continuation of coverage under this subsection will run concurrently with the continuation of coverage provided in subsection (b) of this section. The amount of the contributions will not exceed the maximum permitted under applicable federal law. To the extent required by USERRA, a qualified beneficiary who has elected to exercise his or her continuation of coverage rights under USERRA will be treated as a Participant under the Plan. If continuation coverage is elected,

coverage will be maintained, and Medical Care Expenses reimbursed, as provided in this Article.

The right of a Participant, Spouse or Dependent to continuation coverage under USERRA will terminate on the earlier of the date coverage is terminated for failure to pay a required premium, or the date on which the Employer is no longer required to maintain coverage under USERRA.

7.15 Forfeitures

(a) Except as otherwise provided in section 7.9(c) (regarding certain individuals who may be reimbursed from prior Plan Year HCSA amounts for expenses incurred during a Grace Period), any balance remaining in a Participant's HCSA for a Plan Year on the last day of July immediately following the end of the Plan Year after all reimbursements have been made for expenses incurred during the Plan Year will be forfeited as soon as practicable thereafter and treated as experience gains.

(b) All forfeitures under the Health Care Spending Account will be used in the following order: (i) to offset any losses experienced by the Employer during the Plan Year that resulted from reimbursements (i.e., providing HCSA benefits) to all Participants exceeding the contributions paid by those participants; (ii) to defray reasonable Plan administrative expenses; (iii) to reduce employee contributions for the next Plan Year; and (iv) returned to Participants on a per capita and nondiscriminatory basis; provided, however, that no contributions will be returned or allocated to a Participant based on the amounts that the Participant forfeited.

(c) If a Participant fails to claim a HCSA reimbursement (for example, an uncashed reimbursement check) within 12 months of issuance, the unclaimed reimbursement will be forfeited and applied as described in subsection (b) of this section.

7.16 Statements

The Plan will provide each Participant who has had contributions made to a HCSA during the Plan Year a written statement showing a reasonable estimate of the amount of Medical Care Expenses reimbursed for that Plan Year, in accordance with applicable provisions of this Plan.

ARTICLE VIII
Dependent Care Spending Account

8.1 Dependent Care Spending Account

This Dependent Care Spending Account (DCSA) is intended to qualify as a nontaxable dependent care assistance program under section 129 of the Code, and will be interpreted in a manner consistent with the requirements of sections 125 and 129 of the Code and the Treasury regulations issued under those sections. All other provisions of this Plan apply to and govern this DCSA, unless expressly contradicted by a provision of this Article or of any applicable law or regulation.

8.2 Dependent Care Spending Account Benefits

An Eligible Employee may elect to participate in the DCSA by electing to (a) receive benefits in the form of reimbursements for Dependent Care Expenses from the DCSA, and (b) to pay for those DCSA benefits with Salary Reduction Contributions and Non-elective Employer Contributions. Unless an exception applies (as described in section 3.7), any such election is irrevocable for the duration of the Plan Year to which it relates.

8.3 Eligible Dependent Care Expenses

Under the DCSA, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Plan Year for which an election is in force. In addition, certain individuals may receive reimbursement for Dependent Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their DCSA for that Plan Year in accordance with Section 8.9(d).

(a) Incurred. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed, charged, or pays for the Qualifying Dependent Care Services.

(b) Dependent Care Expenses. "Dependent Care Expenses" means expenses that are: considered employment-related expenses under section 21(b)(2) of the Code and the Treasury regulations issued under that section (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Participant to obtain Qualifying Dependent Care Services. Dependent Care Expenses exclude:

(i) any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan (if only a portion of a Dependent Care Expense has been reimbursed elsewhere – for example, because the Spouse's dependent care assistance program imposes maximum benefit limitations – the DCSA can reimburse the remaining portion of such expense if it otherwise meets the requirements of this

Article); and any amount paid to:

(A) an individual with respect to whom a personal exemption is allowable under Code section 151(c) to a Participant or his or her Spouse;

(B) a Participant's Spouse;

(C) a Participant's child (as defined in Code section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or

(D) a parent of a Participant's under age 13 qualifying child as defined in Code section 152(a)(1) (e.g., a former Spouse who is the child's noncustodial parent).

(c) Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means services that:

(i) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCSA and during the Plan Year; and

(ii) are performed:

(A) in the Participant's home; or

(B) outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

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

8.4 Establishment of Dependent Care Spending Account

(a) The Plan Administrator will establish and maintain a DCSA for each Participant for each Plan Year for which the Participant elects to participate in the DCSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The

account will be merely a recordkeeping account for purposes of tracking contributions and determining forfeitures under section 8.14.

(b) Subject to section 8.6, a Participant's DCSA will be periodically credited during the Plan Year with the sum of: (a) the Participant's Salary Reduction Contributions, and (b) any Non-elective Employer Contributions to be allocated to a Participant's DCSA for the Plan Year. A Participant's DCSA for a Plan Year will be debited for any reimbursement of Medical Expenses incurred during the Plan Year (or for reimbursement of Dependent Care Expenses incurred during any Grace Period to which he or she is entitled as provided in section 8.9(d)).

(c) The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCSA, less any prior reimbursements (i.e., it is based on the amount credited to the DCSA at a particular point in time). Thus, a Participant's DCSA may not have a negative balance during a Plan Year.

8.5 Participant Contributions for Cost of Coverage for DCSA Benefits

The annual contribution for a Participant's DCSA benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in section 8.6.

8.6 Limitations on Contributions.

The maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions that a Participant may elect to allocate to his or her DCSA for any Plan Year is $5,000 (or $2,500 for a Participant who is married, meaning he or she has a Spouse, and files a separate tax return) or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

(i) the amount specified in the first sentence of this section, as determined based on the Participant's marital and filing status;

(ii) the Participant's earned income for the calendar year; or

(iii) the Participant's Spouse's earned income for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense, and is either (A) a student, or (B) physically or mentally incapable of self-care will be deemed to have earned income in the amount specified in section 21(d)(2) of the Code).

For purposes of this section, "earned income" has the meaning given that term in section 129(e)(2) of the Code. The minimum amount that a Participant may elect to contribute to the DCSA with respect to any Plan Year is $240.

8.7 Timing of Contributions

Except as permitted under section 3.7, Salary Reduction Contributions for the Plan Year must be contributed in substantially equal payments throughout the Plan Year. The number of payments must equal the number of pay periods in the Plan Year (that are expected to occur with respect to an individual Participant), or portion thereof, during which the Employee is a Participant in this Plan. The payments must be made on each pay date while the individual is a Participant.

8.8 Limitation on Election Changes

(a) A Participant may revoke his DCSA election and make a new DCSA election for the remainder of the Plan Year in accordance with section 3.7. If a Participant makes a new election, the amount of the new election, reduced by the amount of prior reimbursements for that Plan Year, will apply only to Dependent Care Expenses incurred after the election is effective. Any change in an election under section 3.7 affecting annual contributions to the DCSA also will change the maximum reimbursement benefits for the balance of the Plan Year commencing with the Election Change. The maximum reimbursement benefits for the balance of the Plan Year will be the sum of (i) the contributions, if any, made by the Participant as of the end of the portion of the Plan Year immediately preceding the change in election, and (ii) the total contributions scheduled to be made by the Participant during the remainder of the Plan Year to the DCSA, reduced by (iii) all reimbursements during the Plan Year.

(b) A Participant may revoke his DCSA election on a retroactive basis during the Plan Year if, at the time of the election and at all times thereafter, the Participant did not have a Dependent, and the Plan Administrator determines that the election clearly was based on a mistake of fact.

8.9 Limitations on Benefits

(a) The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Plan Year (reduced by prior reimbursements during the Plan Year) will only be available during the Plan Year to the extent of the actual amounts credited to the Participant's DCSA pursuant to section 8.4. No reimbursement will be made to the extent that it would exceed the balance in the Participant's account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Plan Year, less any prior reimbursements). Payment will be made to the Participant in cash as reimbursement for Dependent

Care Expenses incurred during the Plan Year (or related Grace Period that applies to the Participant under subsection (d) of this section) for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) Except as otherwise provided in subsection (d) of this section, the DCSA will not reimburse any Participant in any Plan Year for any expense that:

(i) was not a Dependent Care Expense;

(ii) was not incurred during the Plan Year;

(iii) was submitted after the earlier of 30 days following the date of termination of employment or the last day of July of the following Plan Year; or

(iv) exceeds the lesser of the following:

(A) the amount of the Participant's election for the Plan Year in effect on the date the expense was incurred reduced by the amount of prior reimbursements made for that Plan Year; or

(B) the Participant's DCSA balance on the date the expense was incurred.

If the expense for which reimbursement is sought exceeds subparagraph (iv)(B), but not subparagraph (iv)(A), the amount of the expense in excess of subparagraph (iv)(A) will be held for future reimbursement consideration within that Plan Year.

(c) The Plan will not reimburse any Participant any amounts in excess of the Participant's applicable statutory limit (as defined in section 8.6), when combined with the prior reimbursements to that Participant for that Plan Year.

(d) Grace Periods; Special Rules for Claims Incurred During a Grace Period. Notwithstanding any contrary provision in this Plan and subject to the conditions of this section, an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her DCSA at the end of the Plan Year to which that Grace Period relates if he or she is a Participant with DCSA coverage that is in effect on the last day of that Plan Year.

(i) Prior Plan Year DCSA amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, they may not be used to reimburse Medical Care Expenses.

(ii) Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with sections 8.10, 8.11 and 8.12 will be reimbursed first from any available prior Plan Year DCSA amounts and then from any amounts that are available to reimburse expenses that are

incurred during the current Plan Year. An individual's prior Plan Year DCSA amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such prior Plan Year DCSA amounts.

(iii) Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than March 31 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from prior Plan Year DCSA amounts. Any prior Plan Year DCSA amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in section 8.14.

8.10 Claims for Reimbursement

(a) A Participant must request reimbursement of Dependent Care Expenses by completing the appropriate application form that includes:

(i) a written statement or confirmation from an independent third party stating that the Dependent Care Expense was incurred, the nature and amount of that expense, and the date it was incurred;

(ii) the name, address, and social security number or tax identification number of the person, organization, or entity to whom the Dependent Care Expense was or will be paid, or in the case of an organization exempt from tax under section 501(c)(3) of the Code, the name and address of that organization;

(iii) a written statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

(iv) the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in section 8.6; and

(v) any other information that the Claims Administrator may require.

The request must be accompanied by bills, invoices, receipts or other statements or certifications from an independent third party showing that the Dependent Care Expenses were incurred and the amounts of these expenses, along with any

additional documentation that the Claims Administrator may require. The application may be made before or after the Participant pays the expense, but not before the Participant incurs the expense.

(b) If a Participant fails to submit a claim within 92 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Claims Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 30 days after termination of employment. If the Participant dies, the Participant's Spouse (or if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article in accordance with section 8.13.

8.11 Determination of Claims

The Plan Administrator will notify a claimant in writing that his or her claim has been denied within 90 days after its receipt of the claim or any information requested by the Claims Administrator that is necessary to decide the claim. This period may be extended an additional 90 days for matters beyond the Plan's control, if the Claims Administrator notifies the claimant in writing of the circumstances that require the extension before the initial 90-day period expires.

8.12 Procedures for Appealing the Denial of a Claim

(a) A claimant has 60 days from the date he or she receives notice of a claim denial to appeal the denial in writing to the Plan Administrator.

(b) The Plan Administrator will notify the claimant of its decision on the appeal no later than 60 days after the Plan Administrator receives the appeal**.** This period may be extended an additional 60 days with advance written notice from the Plan Administrator.

(c) The Plan Administrator's decision is final.

(d) A claimant's Authorized Representative may act on the claimant's behalf at any stage of these claims procedures. Once an Authorized Representative has been appointed, the Plan will direct all information and notices to the Authorized Representative. The Plan will provide the claimant copies of all notifications regarding decisions, unless the claim provides specific written direction otherwise. Any reference to a claimant in these claims procedures is intended to include the claimant's Authorized Representative. For this purpose, "Authorized Representative" means an individual who a claimant has authorized in writing to file and pursue a claim or appeal on the claimant's behalf. An assignment of payment to a health care provider is not the appointment of an Authorized Representative under these claims procedures.

8.13 Reimbursements From DCSA After Termination of Participation

When a Participant ceases to be a Participant under section 2.2, the Participant's Salary Reduction Contributions and election to participate will terminate on the last day of the pay period for which a required contribution was made. Except as otherwise provided in section 8.9(d) (regarding certain individuals who may be reimbursed from prior Plan Year DCSA amounts for expenses incurred during a Grace Period), the Participant will be reimbursed only for Dependent Care Expenses incurred before the Participant's DCSA coverage terminates, and only if a request for reimbursement is made as provided in sections 8.10 and 8.11. However, the Participant' Spouse (or if none, the Participant's executor or administrator) may claim reimbursement for any Dependent Care Expenses incurred during the Plan Year prior to the date the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 8.9(d)), provided that the Participant's Spouse (or if none, the Participant's executor or administrator) files a claim within 30 days after the date that the Participant ceases to be a Participant.

8.14 Forfeitures

(a) Except as otherwise provided in section 8.9(d) (regarding certain individuals who may be reimbursed from prior Plan Year DCSA amounts for expenses incurred during a Grace Period), any balance remaining in a Participant's DCSA for a Plan Year on the last day of July immediately following the end of the Plan Year after all reimbursements have been made for expenses incurred during the Plan Year will be forfeited as soon as practicable thereafter and treated as experience gains.

(b) All forfeitures under the DCSA will be used in the following order: (i) to offset any losses experienced by the Employer during the Plan Year that resulted from reimbursements to all Participants exceeding the contributions paid by those Participants; (ii) to defray reasonable Plan administrative expenses; (iii) to reduce employee contributions for the next Plan Year; and (iv) returned to Participants on a per capita and nondiscriminatory basis; provided however, that no contributions will be returned or allocated to a Participant based on the amounts that Participant forfeited.

(c) If a Participant fails to claim a DCSA reimbursement (for example, an uncashed reimbursement check) within 12 months of issuance, the unclaimed reimbursement will be forfeited, and applied as described in subsection (b) of this section.

8.15 Statements

The Plan will provide each Participant who has had contributions made to a DCSA during the Plan Year a written statement showing a reasonable estimate of the amount of Dependent Care Expenses reimbursed for that Plan Year, in accordance with applicable provisions of this Plan.

ARTICLE IX

Amendment or Termination

9.1 Right to Amend

The City Council may amend the Plan by resolution at any time; however, no amendment may have the effect of modifying any Participant's benefit election in effect at the time of the amendment or denying any Participant's benefit claim incurred, but not paid, before the amendment date, unless the City Council determines the amendment is necessary to comply with applicable law.

9.2 Right to Terminate

The City Council has the authority to terminate the Plan by resolution at any time in whole or in part; but, no such termination may prejudice any claim or benefit under the Plan that was incurred but not paid before the termination date.

ARTICLE X

Administration

10.1 Plan Administrator

The Employer is the Plan Administrator. The Plan Administrator's principal duty is to see that the Plan is administered in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

10.2 Powers and Duties

The Plan Administrator has full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers include, but are not limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(b) To determine and set the cost associated with each Benefit Option offered under this Plan. The Plan Administrator may change the cost at any time before or during a Plan Year without prior notice to Participants or the Employer.

(c) To make and enforce the rules and regulations it deems necessary or proper to efficiently administer the Plan, including establishing any claims procedures that may be required by law.

(d) To interpret the Plan. The Plan Administrator's good faith interpretation is final and conclusive on all persons claiming benefits under the Plan.

(e) To decide all questions concerning the Plan, including the eligibility of any person to participate in the Plan.

(f) To appoint agents, counsel, accountants, consultants, and other persons required to assist in administering the Plan.

(g) To allocate and delegate the Plan Administrator's responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, including, but not limited to, delegating certain claims administration duties to a Claims Administrator, provided that any such delegation is set out in a written instrument signed by the Plan Administrator and the designated party.

(h) To communicate in writing to any insurer or other supplier or administrator of benefits under this Plan all information required to carry out the provisions of the Plan.

(i) To notify the Participants in writing of any substantive amendment to the Plan, termination of the Plan, or change in benefits available under the Plan.

The powers and duties allocated to the Plan Administrator and described in this section apply only with respect to a claim arising under the Benefit Options or the administration of the Benefit Options to the extent that that power or duty is not allocated (either expressly or by implication) to the individuals or entity appointed to serve as administrator of any of the Benefit Options.

10.3 Examination of Records

The Plan Administrator will make available to each Participant the records under the Plan that pertain to that Participant for examination at reasonable times during normal business hours.

10.4 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator will be entitled (to the extent permitted by law) to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions of, the administrators of any of the plans offered within the Plan, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

10.5 Nondiscriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator will exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

10.6 Standard of Review

The Plan Administrator will perform its duties as the Plan Administrator, and in its sole discretion will determine appropriate courses of action, in light of the purpose for which this Plan is established and maintained. The Plan Administrator has the sole discretion to interpret all Plan provisions and make all determinations as to whether any particular Participant is entitled to receive any benefit under the terms of this Plan. The Plan Administrator's construction of the terms of the Plan will be final and legally binding on all parties, if there is a rational basis for that construction.

Any interpretation of the Plan or other action of the Plan Administrator is subject to review only if the interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator must be based only on the evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties will be paid by the Employer.

10.7 Insurance Contracts

The Employer will have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of and be retained by the Employer, to the extent permissible under applicable law.

In the event of a conflict between the terms of this Plan and the terms of an insurance contract under a Benefit Option, the terms of the insurance contract shall control as to those Participants receiving coverage under the insurance contract. For this purpose, the insurance contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

ARTICLE XI

Miscellaneous Provisions

11.1 Information to be Furnished

Participants must provide the Plan Administrator the information and evidence, and must sign the documents, that the Plan Administrator reasonably requests in administering the Plan.

11.2 Limitation of Rights

The establishment or amendment of this Plan, and the payment of any benefits under the Plan, do not confer upon any Participant or other person any legal or equitable right against the Employer, except as provided in this plan document.

11.3 Governing Law

This Plan must be construed, administered and enforced according to the laws of the State of California except as may be preempted by federal law.

11.4 Facility of Payment

If the Plan Administrator deems any person entitled to receive any amount under this Plan incapable of receiving or disbursing that amount by reason of minority, death, illness, infirmity, mental incompetence, or incapacity of any kind, the Plan Administrator may, in its discretion, take any one or more of the following actions:

(a) Apply the amount directly for the comfort, support, and maintenance of the person.

(b) Reimburse any person for any support previously supplied to the person entitled to receive the payment.

(c) Pay the amount to a legal representative or guardian or any other person selected by the Plan Administrator for the comfort, support and maintenance of the person entitled to receive the amount, including without limitation, any relative who has undertaken, wholly or partially, the expense of that person's comfort, care, and maintenance, or any institution caring for that person. The Plan Administrator may, in its discretion, deposit any amount due to a minor to the minor's credit in any savings or commercial bank chosen by the Plan Administrator.

11.5 Lost Payee

Any amount due to a Participant or beneficiary is forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. These forfeited amounts will be applied toward the Plan's administrative expenses, or will revert to the Employer. However, if a claim is later made by the Participant or beneficiary and is payable, the forfeited amount will be reinstated through a special

contribution by the Employer to the Plan. The Plan Administrator will prescribe uniform and nondiscriminatory rules for carrying out this provision.

11.6 No Guarantee of Tax Consequences

Notwithstanding anything in this Plan document to the contrary, the Employer does not ensure or guarantee that any amounts paid to a Participant under the Plan, or any amounts by which a Participant's wages are reduced pursuant to Article III, will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It is the obligation of each Participant to notify the Employer if the Participant has reason to believe that any payment made or to be made to the Participant is not excludable from the Participant's gross income for federal, state, or local income tax purposes.

11.7 Funding

Payments due under the Plan will be made from the Employer's general assets or otherwise provided by a third-party insurance company with whom the Plan Administrator has contracted to provide certain benefits. No funds will be placed in escrow or earmarked to pay benefits.

11.8 Indemnification of Employer by Participant

If a Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and the payments do not qualify for that treatment under the Code, the Participant must indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local income tax, or Social Security tax from those payments or reimbursements. This indemnification and reimbursement will not exceed the sum of the amount of additional federal and state income tax that the Participant would have owed if the payments had been made to the Participant as regular cash Compensation plus the Participant's share of any Social Security tax that would have been paid on that Compensation.

11.9 No Contract of Employment

Nothing herein contained is intended to be or will be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

11.10 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in section 7.14 with respect to HCSA benefits and section 8.14 with respect to DCSA benefits, and then by the Employer.

11.11 Compliance with Code and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan will be construed, operated, and administered

accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

11.12 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

11.13 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan will be given effect to the maximum extent possible.

ARTICLE XII

HIPAA Provisions for HCSA

12.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the Health Care Savings Account (HCSA). When this health information is provided from the HCSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI.

For purposes of this Article, "Protected Health Information" means information that is created or received by the HCSA and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living, or deceased for a period of 50 years following the death of the individual.

The Employer will have access to PHI from the HCSA only as permitted under this Article or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the statutory provisions of which are incorporated herein by reference.

12.2 Permitted Disclosure of Enrollment/Disenrollment Information

The HCSA may disclose to the Employer information on whether the individual is participating in the HCSA.

12.3 Permitted Uses and Disclosure of Summary Health Information

The HCSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the HCSA.

For purposes of this section, "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

12.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted or required by law, and subject to the conditions of disclosure described in section 12.5 and obtaining written certification pursuant to section 12.7, the HCSA may disclose PHI to the Employer, provided the Employer uses or discloses the PHI only for Plan Administration Purposes. For this purpose, "Plan Administration Purposes" means administration functions performed by the Employer on behalf of the HCSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

The Employer will not use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

12.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that, with respect to any PHI (other than enrollment/disenrollment and Summary Health Information, which are not subject to these restrictions) disclosed to it by the HCSA, it will:

(a) not use or further disclose the PHI other than as permitted or required by the HCSA or as required by law;

(b) ensure that any agent, including a subcontractor, to whom it provides PHI received from the HCSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

(c) not use or disclose the PHI for employment-related actions and decisions or in connection with any of the Employer's other benefits or employee benefit plans;

(d) report to the Plan any use or disclosure of the information that it becomes aware of that is inconsistent with the permissible uses or disclosures;

(e) make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

(f) make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

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

(h) make its internal practices, books, and records relating to the use and disclosure of PHI received from the HCSA available to the Secretary of Health and Human Services for purposes of determining the HCSA's compliance with HIPAA's privacy requirements;

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

(j) ensure the adequate separation between the HCSA and the Employer required by 45 CFR § 504(f)(2)(iii).

The Employer further agrees that, if the Employer creates, receives, maintains, or transmits electronic Protected Health Information, as defined in 45 CFR § 160.103, (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the HCSA, it will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;

(b) ensure that the adequate separation between the Plan and the Employer with respect to electronic PHI is supported by reasonable and appropriate security measures;

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

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

12.6 Adequate Separation Between HCSA and Employer

To satisfy the requirements of section 12.5(j), the following conditions apply:

(a) The Employer will allow only the following persons to access PHI: the Plan Administrator, employees in the Employer's human resources department who are engaged in activities related to plan administration functions, or in other departments that have oversight responsibility for the Plan, including employees with oversight responsibility for claims payment and third-party claims administration.

(b) The access to and use of PHI by the individuals described in section 12.6(a) will be restricted to the plan administration functions that the Employer performs for the HCSA.

(c) An individual described in section 12.6(a) who fails to comply with the Plan provisions relating to the use and disclosure of PHI will be subject to disciplinary action under the Employer's established policies and procedures.

The Employer will ensure that the provisions of this section 12.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

12.7 Employer Certification

The HCSA will disclose PHI to the Employer only after receiving a certification by the Employer that the HCSA incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in section 12.5. Execution of the Plan by the Employer will serve as the required certification.

To record the adoption of the Plan, the City's duly authorized officer has signed this document effective July 1, 2023.

CITY OF SAN DIEGO

BY: _____
Eric K. Dargan
Chief Operating Officer

APPROVED as to the form and legality on_____, 2023.

Mara Elliot, City Attorney

BY: _____
Thomas J. Brady

APPENDIX A
COMPONENT PLAN

1. City / HMO Medical
2. City / PPO Medical
3. City / Kaiser Traditional HMO Medical
4. City / Kaiser Deductible HMO Medical
5. MEA / Sharp HMO Medical
6. MEA / Sharp Deductible HMO Medical
7. POA / Medical
8. Local 145 / Medical
9. City / Delta DHMO Dental
10. City / Delta DPO Dental
11. MEA / Dental
12. Local 127 / Dental
13. City / VSP Vision Plan
14. MEA / Vision
15. City / Health Care Spending Account
16. City / Dependent Care Spending Account
17. City / Basic Term Life Insurance with AD&D
18. City / 401(k) Plan