CITY OF
CHULA VISTA

CAFETERIA BENEFITS PLAN

FOR

THE CITY OF CHULA VISTA

Amended and Restated as of January 1, 2023

Established June 1998

Human Resources Department
City of Chula Vista

SECTION 125 CAFETERIA BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Cafeteria Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan Specifications:

A. EMPLOYER INFORMATION

Name of Employer:	City of Chula Vista
Address:	276 Fourth Ave. Chula Vista, CA 91910
Employer Tax ID:	95-6000690
Nature of Business:	Municipal Government
Name of Plan:	City of Chula Vista Cafeteria Benefits Plan

B. EFFECTIVE DATE

Original Effective Date of Plan:	June 1998
Effective Date of Amendment:	January 1, 2023

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Employee Status:

(1) Benefits-Eligible (Permanent) Employees: Directly employed by the City of Chula Vista in a full- or part-time benefited status. Part- time benefits-eligible employees must be authorized to work at least half-time or 40 hours biweekly.

(2) Full-time Hourly Employees: Directly employed by the City of Chula Vista who are expected and scheduled to work 30 or more hours per week.

(3) Eligible *Variable-Hour* Hourly Employees: *Variable-hour* Hourly employees as defined by the Affordable Care Act (ACA) working an average of 30 or more creditable service hours per

week during the Standard Measurement Period. Eligibility is determined annually.

Length of Service:

(1) Benefits-Eligible (Permanent) and Full-time Hourly Employees: First day of employment in a benefited status.

(2) Eligible, *Variable-Hour* Hourly Employees: First of the month which occurs 60 days following the City's Measurement Period.

D. PLAN YEAR

The current plan year will begin on January 1, 2023, and end on December 31, 2023.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions: (Benefits-Eligible (Permanent) Employees, except members of POA and IAFF bargaining groups)

Flexible Plan Allotment
The maximum amount available to each Participant for the purchase of certain elected benefits (Group Medical Insurance, Group Dental Insurance, Group Vision, Health Care and Dependent/Child Care Flexible Spending Accounts, and Cash Payment Option) are outlined per the MOU or Unrepresented Compensation Summary with non-elective contributions will be:

ACE	$15,564
CONF	$16,064
EXEC, CMGR, CCLK	$18,840
Elected Officials	$18,840
MM, PROF	$16,940
MMCF,MMUC,PRCF,PRUC	$16,940
Non-Safety IAFF	$15,564
SM	$17,440
WCE	$16,440

Non-Elective Contributions (POA and IAFF members):

Employees represented by POA: The employer pays the full cost of the Kaiser Permanente Plan for employees and their dependents. Employees enrolled in any non-Kaiser plan are responsible for paying any amount greater than the cost of the Kaiser plan.

Employees represented by IAFF: The employer pays the full cost of the Kaiser Permanente Plan for employees and their dependents. Employees enrolled in the lowest cost, non-Kaiser, limited network HMO/limited network alternative plan will pay $50 per month and the City will pay the balance of the premium. For the 2023 benefits plan year only, this $50 per month premium will be waived if the Aetna Whole Health (AWH) Southern California HMO is elected. Employees enrolled in the non-Kaiser Full HMO plan will pay $250 per month and the City will pay the balance of the premium. Employees enrolled in the PPO shall receive the value equal to that of employees enrolled in the non-Kaiser Full HMO plan and employees will be responsible for the balance.

Employees represented by POA and IAFF: For dental coverage, the employer will pay an amount equal to the pre-paid dental premium for the coverage level elected.

Non-Elective Contributions (Eligible Hourly Employees):

The annual maximum amount available for each employee for the purchase of group "Employee Only" medical insurance coverage is based on an Affordability Test under the Affordable Care Act. Other plan components of this Section 125 are not available.

Elective Contributions (Salary Reduction):

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made via online enrollment through Munis Employee Self-Service (ESS).

F. AVAILABLE BENEFITS

Each of the following components should be considered a plan that comprises this Plan.

1. Group Medical Insurance

Mandatory for all Benefits-Eligible (Permanent) Employees in the POA and IAFF classifications. Benefits-Eligible (Permanent) Employees in all other groups can waive medical insurance if they are covered by their City Employee Spouse or they can provide evidence of Other Qualified Group Coverage.

Medical enrollment is optional for Eligible Hourly Employees.

The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below. (See Section V of the Plan Document).

2. Group Dental Insurance

Optional for all Benefited-Salaried Employees.

Group dental insurance is not available to Eligible Hourly Employees.

The terms, conditions and limitations for the Group Dental Insurance will be as set forth in the insurance policy or policies described below. (See Section V of the Plan Document).

3. Group Vision Insurance

Optional for all Benefited-Salaried Employees.

Group vision insurance is not available to Eligible Hourly Employees.

The terms, conditions and limitations for the Group Vision Insurance will be as set forth in the insurance policy or policies described below. (See Section V of the Plan Document).

4. Health Care Flexible Spending Account

Optional for all Benefited-Salaried Employees.

Health Care Flexible Spending Accounts are not available to Eligible Hourly Employees.

The terms conditions and limitations for the Health Care Flexible Spending Account will be as set forth in Section VI of the Plan Document and described below:

Minimum Coverage: $24 per Plan Year

Maximum Contribution: $3,050 from all sources per Plan Year.

Recordkeeper: HealthEquity

5. Dependent Care Flexible Spending Account

Optional for all Benefits-Eligible (Permanent) Employees.

Dependent Care Flexible Spending Accounts are not available to Eligible Hourly Employees.

The terms conditions and Limitations for the Dependent Care Flexible Spending Account will be as set forth in Section VII of the Plan Document and described below:

Minimum coverage: $24 per Plan Year

Maximum Coverage: $5,000 per plan year from all sources ($2,500 per plan year from all sources for a married employee filing separate tax returns)

Recordkeeper: HealthEquity

6. Cash Payment Option

Optional for Benefits-Eligible (Permanent) Employees.

Cash Payment Option is not available to Eligible Hourly Employees.

Eligible Flex Plan Allotment remaining after electing mandatory medical coverage may be allotted to this taxable option. Eligibility and limits for the cash option is based on the employee's Compensation Summary or Memorandum of Understanding (MOU).

7. The following benefits are only available through Elective Contributions (Salary Reduction) for Benefited-Salaried Employees:

Hartford plans are not available to Eligible Hourly Employees

Hartford Group Critical Illness
Hartford Group Hospital Indemnity Plan
Hartford Group Accident Plan

The terms condition and limitations for the Hartford programs will be as set forth in Section VIII of the Plan Document.

Administered by: The Hartford

8. Employee Assistance Program	This free and confidential service is available to benefited employees and their household members. The terms condition and limitations for the EAP program will be set forth in Section IX of the Plan Document. Administered by: Health and Human Resource Center, Inc. (dba Aetna Resources for Living)

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of California. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted the 6th Day of December 2022.

By: MARY SALAS

Title: City Mayor

SECTION 125 CAFETERIA BENEFITS PLAN

SECTION 1

PURPOSE

The Employer is establishing this Cafeteria Benefits Plan in order to make a broad range of benefits available to its Employees and their Dependents. The Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits, which when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

"Administrator" means the Human Resources Department of the City of Chula Vista, or other such person or entity that it appoints as its designee.

"Annual Enrollment Period" means the period designated by the Administrator which precedes the commencement of each Plan Year during which Eligible Employees can elect or modify the amount contributed for Benefits.

"**Applicable Law"** means the Internal Revenue Code of 1986, and the same as may be amended from time to time, plus all regulations promulgated with respect thereto. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provision of any legislation which amends, supplements or replaces such section or subsection.

"Benefit Package Option" means a qualified benefit under Code Section 125 (f) that is offered under the Cafeteria (Flexible) Benefits Plan, or an option for coverage under an underlying health plan (such as an HMO or PPO option under a health plan).

"Benefits" or **"Qualified Benefits"** means the following benefits available under the Flex Plan:

(a) Group Medical Insurance
(b) Group Dental Insurance
(c) Group Vision Insurance
(d) Health Care Flexible Spending Account
(e) Dependent Care Flexible Spending Account
(f) Cash Payment Option (Post-Tax)
(g) Health Premiums for Non-Tax Qualified Dependents (Post-Tax)
(h) Certain Hartford Plans available via salary reduction only

In order for a benefit to be qualified, a participant must also meet federal and/or state tax requirements, including Code Section 152, etc.

"Child" means for these purposes will include (1) a natural child, (2) a stepchild, (3) a legally adopted child, (4) a child placed with the employee for legal adoption, (5) a foster child and (6) a child placed under the legal guardianship of the employee. In addition and in order to comply with OBRA 1993: a child will include a child for whom the employee or covered dependent spouse or Life Partner is required to provide coverage due to a Medical Child Support Order. A Qualified Medical Child Support Order (QMCSO) will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law.

"**Code"** means the Internal Revenue Code of 1986, as amended.

"Dependent" means an individual including:

(a) Participant's legal spouse;
(b) Life Partner (see definition of Life Partner)
(c) Child of the employee, spouse, or Life Partner who is under 26 years of age;

And

(d) Unmarried child of any age of the employee, spouse or Life Partner who is incapable of self-support due to mental or physical handicap and such handicap began before attainment of limiting age

"Dependent Care Flexible Spending Account" shall have the same meaning assigned to it by Section 7.02 of the Plan Attached hereto as Exhibit A.

"Effective Date" of this Flex Plan was June 1998.

"Eligible Employee" means any active, full- or part-time employee of the City of Chula Vista employed in a benefits-eligible (permanent) status.

"Eligible Hourly Employee" means full-time hourly employee as defined by the Affordable Care Act.

"Employee" means an individual that the Employer classifies as active, full-time or part-time, who is on the Employer's W-2 payroll, include elected and appointed officials but does not include the following: (a) any leased employee or an individual classified as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individuals are on the Employer's W-2 payroll or determined by the IRS or others to be common-law employees of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be common-law employees of the Employer.

"Employer" means the City of Chula Vista.

"Enrollment Period" means the period designated by the Administrator which allows employees to select Benefits for the Plan Year. For new hires, the Enrollment Period shall be the first 30 days following each new Eligible Employee's hire date. For existing employees, the window during which they may add or drop their health insurance, or make changes to their coverage is called the **Open Enrollment Period.**

"Entry Date" shall mean the date that an Eligible Employee shall become a Participant:

(a) on the first day of the Plan Year if the Eligible Employee's elections are made during the annual Enrollment Period, or
(b) on the first day of employment or as provided in the employee's MOU, provided the new hire makes such request within 30 days after the date of employment, or
(c) on the first day coinciding with the date of satisfying the plan's eligibility requirements.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"**Plan Year"** means the twelve-month period commencing on January 1 and ending on December 31.

"Health Care Flexible Spending Account" shall have the meaning assigned to it by Section 6.01 of the Plan attached hereto as Exhibit A.

"Health Plan" means the group medical, dental and vision plans maintained by the City for its employees, as amended from time to time and are automatically incorporated by reference under this Cafeteria Benefits Plan. A Participant may request a copy of the plan(s) from the Human Resources Benefits Division.

"HIPAA" Means the Health Insurance Portability and Accountability Act of 1996 as amended.

"Life Partner" means: both the employee and his/her partner are eighteen (18) years of age or older and are capable of consenting to the domestic partnership; neither can be married to another or be a member of another domestic partnership; cannot be related by blood in a way that would prevent them from being married to each other in this state; they must share the same principal place of abode, with the intent to continue doing so indefinitely (this means that both partners share the same residence, however, it is not necessary that the legal right to possess the common residence be in both names); They are jointly financially responsible for "basic living expenses; defined as basic food, water, shelter, and any other basic living expenses. Life partners do not need to contribute equally to the cost of these expenses as long as they agree that both are responsible for the cost; neither have had a different domestic partner in the last six (6) months unless a previous domestic partnership terminated by death.

"Non-elective Contribution(s)" means any amount which the Employer, pursuant to Labor Agreements, contributes on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Plan Options offered under the Plan. The amount shall be calculated for each plan year in a uniform and nondiscriminatory manner and in the case of POA and IAFF employees will be based upon the Participant's elected coverage dependent status, and for all others may be based on the commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the enrollment material, the Employer may make non-elective contribution available to Participants and allow Participants to allocate the Non-elective Contributions among the various Benefit Plan Options offered under the Plan in a manner set forth in the enrollment material. In no event will any Non-elective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the enrollment material.

"Other Qualifying Medical Coverage" means other employer-sponsored medical benefits that provide Minimum Essential Coverage as defined in the Affordable Care Act (ACA), and does not include Medicare, Medi-Cal, TriCare, and benefits purchased through an Exchange as established under the ACA.

"Participant" means an eligible employee.

"Period of Coverage" means that portion of the Flex Plan Year for which one is a Participant. In no event shall the period of coverage commence prior to, nor terminate after, the commencement and ending dates of the Flex Plan Year.

"Qualified Benefits" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106 (b), 117,124, 127 or 132 and any other benefit permitted by the Income Tax Regulations (i.e. any premiums for Life Partners who are not otherwise tax qualified dependents). Long Term Care is not a "Qualified Benefit."

SECTION III

ELGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the entry date specified or the effective date of the Plan, whichever is later. The Employer must notify the Employee of his eligibility to participate in the Plan so that the Employee shall complete the necessary enrollment forms on or before the entry date.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by online enrollment through Munis ESS, during an Enrollment Period, which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's online enrollment shall be completed prior to the beginning of the Plan Year, and shall not be effective prior to the date such form is submitted to the Employer. Any online enrollment by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently completed online enrollment.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Code and the regulations thereunder. Notwithstanding anything to the contrary herein, to the extent required by the Health Insurance Portability and Accountability Act of 1996, the Plan shall permit special enrollment period for employees who have previously declined coverage under the Plan; a new dependent may also justify a special enrollment period.

3.03 DEFAULT ENROLLMENT:

Except for POA and IAFF employee groups, all new hire Benefits-Eligible (Permanent) employees who fail to make their elections within 30 days of their hire date will automatically be enrolled in the City's least costly medical plan with Employee Only coverage. POA and IAFF employees will be automatically enrolled in the Kaiser "Employee Only" plan.

During Open Enrollment, employees who do not complete enrollment within the Open Enrollment period will have their current medical and life insurance automatically continued into the next Plan year as if the Employee elected to keep them. All other coverage, including Health Care and Dependent Care

Flexible Spending Accounts will stop. Eligible non-IAFF and non-POA employees may have eligible Flex Plan Allotment funds remaining after the health coverage election placed in the taxable Cash Payment Option as provided in the employee's Compensation Summary or Memorandum of Understanding (MOU).

3.04 TERMINATION OF PARTICIPATION: A Participant's coverage will stop on the last day of the month in which eligibility ends for any of the following reasons:

a. The date the Participant terminates employment by death, disability, retirement, or other separation from service; or
b. The date the Participant ceases to work for the Employer as an eligible Employee;
c. The date of termination of the Plan;
d. The first date a Participant fails to pay required contributions while on a leave of absence with benefits, or
e. The date an employee begins a leave of absence without benefits.

Dependent coverage will end the earlier of: the last day the employee's coverage ends or on the last day of the month in which he or she is no longer an eligible Dependent.

3.05 SEPARATION FROM SERVICE: The Employer shall, on a reasonable and consistent basis, permit an Employee who separates from the employment service of the Employer during a Plan Year to revoke his existing elections and terminate the receipt of benefits for the remaining portion of the Plan Year.

3.06 QUALIFYING LEAVE UNDER FAMILY AND MEDICAL LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying paid or unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to the benefits under Section V and Section VI of the Plan on the same terms and conditions as though they were still an active Employee. If the Employee fails to return to work after such leave for any reason other than the serious illness of the employee or the family member for whom the leave was granted or through no fault of the employee, they will be required to pay all Cafeteria Benefits Plan monies paid to them, or on their behalf during the absence.

3.07 COVERAGE WHILE ON A LEAVE OF ABSENCE WITH BENEFITS: Employees who are authorized to take a leave of absence with benefits (e.g. Military Leave as approved by the City Council) will continue to be covered under the Plan until the expiration of their leave.

3.08 COVERAGE WHILE ON A LEAVE OF ABSENCE WITHOUT BENEFITS: Employees on an unpaid leave of absence for any reason other than those

under Section 3.06 and 3.07 are no longer eligible for participation in the Plan. If an employee returns from an unpaid leave of absence without benefits, the date the coverage is reinstated will depend on the employee's date of return. If the employee returns to work on or before the 15th of the month, coverage will be reinstated retroactive to the first of the month. If an employee returns after the 15th of the month, coverage will be reinstated the first of the following month.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may complete online enrollment before the end of the current plan year revising the rate of his/her contributions or discontinuing such contributions effective as of the first day of the following Plan Year. The Participant's Elective Contributions will automatically terminate the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the Plan Year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status: A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, ineligibility based on reaching the dependent status age limit, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of

absence and change in work site. If the eligibility for either the Cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if the benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his/her previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;

(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements; and

(5) Residency change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage as specified in the insurance policy.

(b) Special HIPAA Enrollment Rights. If a Participant or a Participant's Dependent enrolls in the health insurance plan pursuant to special enrollment rights under HIPAA, the Participant may make a corresponding change in election under this Plan. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant or a Participant's Dependent who is enrolled in a medical plan of the Employer becomes entitled to 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 cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan. However, if an employee chooses to purchase coverage through Medicare or Medicaid instead through the City, the employee will lose his/her Flex Allotment to any health benefits plan offered by the City.

(e) Family and Medical Leave Act. If an Employee is taking leave under the rules of the Family and Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

4.03 OTHER EXCEPTIONS TO THE IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year

election changes and apply to all qualified benefits except for a Health Care Flexible Spending Account, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the Plan Year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or Dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the Benefit Package Option that has decreased in cost during the year. If the increased or decreased cost of a Benefit Package Option under the Plan is insignificant, the Participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i.) With no loss of coverage. If the coverage under a Benefit Package Option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another Benefit Package Option providing similar coverage.

(ii.) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another Benefit Package Option providing similar coverage, or drop coverage if no similar Benefit Package Option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent 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 the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse/dependent's plan or by the spouse/dependent's employer, or (2) option changes are initiated by the spouse/dependent's employer or by the spouse/dependent through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her dependent.

(a) Coverage through Covered California Plan. An employee may revoke election under the City group health plan if the employee qualifies for Special Enrollment Period under the Covered California Plan (Marketplace). The employee's revocation must correspond to his or her intended enrollment. The Covered California Plan must begin by the day immediately following the last day of the revoked coverage. However, if an employee chooses to purchase coverage through Covered California instead through the City, the employee will lose his/her Flex Allotment to any health benefits plan offered by the City.

4.04 CASH PAYMENT OPTION: Available eligible amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement and as specified in the Participant's MOU or Compensation Summary.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account, or if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP HEALTH INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group health insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be required in Items F(1), F(2), and F(3) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in items F(1), F(2), and F(3) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Health Insurance Benefit Plans by contributing monthly (subject to taxation) 102% of the amount of the premium for the desired benefits during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for the continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

However, eligibility for tax qualified benefits will be subject to all state and federal regulations. In order to receive tax free benefits, a participant must meet all other state and federal eligibility guidelines.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provision of the Uniformed Services Employment and Reemployment Rights Act of 1994.

SECTION VI

HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN

6.01 The Plan Document for this option is included in the attached Exhibit A and is incorporated by reference.

SECTION VII

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

7.01 The Plan Document for this option is included in the attached Exhibit A and is incorporated by reference.

SECTION VIII

HARTFORD GROUP CRITICAL ILLNESS, GROUP HOSPITAL INDEMNITY AND GROUP ACCIDENT INSURANCE

8.01 The Plan Document for these options is included in the attached Exhibit B and is incorporated by reference.

SECTION IX

EMPLOYEE ASSISTANCE PROGRAM

9.01 The Plan Document for this benefit is included in the attached Exhibit C and is incorporated by reference.

SECTION X

AMENDMENT AND TERMINATION

10.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered Dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively, which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provision or any supplements to the Plan and may merge or combine supplements or add additional supplement to the Plan, or separate existing supplements into an additional number of supplements.

10.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XI

ADMINISTRATION

11.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

11.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

11.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

a. General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulation promulgated thereunder.

c. Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquires as to or inspect the accounts or records with respect to other Participants.

11.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

11.05 LIABILITY OF ADMINISTRATOR**:** Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses, (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

11.06 DELEGATION OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibility which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

11.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

11.08 CLAIM FOR BENEFITS**:** To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

11.09 PROTECTED HEALTH INFORMATION: The provisions of this Section shall be effective on April 14, 2004 or at such other date required by 45 CFR Section 164.534. The Plan may disclose PHI to employees of the Employer with employee benefits responsibility or to employees with oversight responsibility for third party administrator claims administration. Access to and use by such individual must be restricted to plan administration functions that the plan sponsor performs for the Plan. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Plan may disclose PHI to such individual only if the Employer certifies that

the Plan documents have been amended to incorporate the following specific provisions, and the Employer agrees to comply with them. The Employer will:

- Not use or further disclose PHI other than as permitted by the plan documents or as required by law;
- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Report to the Plan any use of disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make available to Plan participants, consider their amendments, and upon their request, provide them with an accounting of PHI disclosures;
- Make its internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and
- Will, if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses no disclosure to those purposes that make the return or discretion of the information infeasible.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 164.501, which is individually identifiable health information that is maintained or transmitted any a covered entity, as defined in 45 CFR Section 16.4104.

SECTION XII

MISCELLANEOUS PROVISIONS

12.01 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and release as shall be required by the Administrator.

12.02 NON-ASSIGNABILITY**:** No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance,

pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

12.03 CONSTRUCTION:

(a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

(b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

12.04 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1) as to contributions and benefits nor to provide more that 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total non-taxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at a risk of possible discrimination), then notwithstanding any other provision contained herein to the contrary, and in accordance with the applicable provision of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

12.05 ERISA: The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provision of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.