CONTRA COSTA COUNTY § 125 BENEFITS PLAN

Restated as of
January 1, 2017

Contra Costa County § 125 Benefits Plan

Table of Contents

INTRODUCTION

Effective January 1, 1989, Contra Costa County (the "County") established the "Contra Costa County Dependent Care Assistance Program" for the benefit of eligible employees. Effective January 1, 1991, the County established the "County of Contra Costa Premium Conversion Plan" for the benefit of eligible employees. Effective January 1, 1997, the County integrated these two plans, in conjunction with the introduction of a new Health Care Spending Account Program. These plans became the "Contra Costa County §125 Benefits Plan" (the "Plan"). The Plan was amended and restated effective January 1, 2010. The Plan is now amended and restated effective January 1, 2017, with the introduction of the new Health Savings Account Program. The purpose of the Plan is to provide eligible employees a choice between certain taxable and nontaxable benefits, including those listed above as well as Medical, Dental and Vision plans, offered through the County or PEMHCA.

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 the Code.

ARTICLE I

Definitions

As used herein, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context. Words in the masculine gender shall be deemed to include the feminine gender and words in the feminine gender shall be deemed to include the masculine gender; and, unless the context otherwise requires, the singular shall include the plural and the plural the singular. Any headings herein are included for reference only and are not to be construed so as to alter any of the terms of the Plan.

1.01 Benefit Option means one or more non-taxable programs available in accordance with Section 4.01 of this Plan.

1.02 Board of Supervisors means the Board of Supervisors of the County of Contra Costa.

1.03 Change in Status Qualifying Event means that a Participant may revoke his election and make new elections with respect to the remainder of the Plan Year in accordance with the circumstances listed in Section 4.08.

1.04 COBRA means the extension of medical coverage that must be offered in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, along with any amendments to such law and any pertinent Treasury regulations, rulings, notices or other promulgations.

1.05 Code means the Internal Revenue Code of 1986, as amended from time to time, along with any pertinent Treasury regulations, rulings, notices or other promulgations. Reference to any section or subsection of the Code includes references to any comparable or successor provisions of any legislation that amends, supplements or replaces such section or subsection.

1.06 Compensation means a Participant's salary, as determined by the County.

1.07 County means the County of Contra Costa, California.

1.08 Dependent means for purposes of accident or health coverage (to the extent funded under the Premium Conversion Program), a dependent who is defined under Code Section 105(b) and is eligible to participate in County-provided health plan coverage.

Special definitions of "Dependent" may be provided under the Dependent Care Assistance Program and the Health Care Spending Account, which definitions shall prevail for purposes of those programs.

1.09 Dependent Care Assistance Program means the benefit as described in Article X.

1.10 Effective Date of Restatement means January 1, 2017.

1.11 Election Form means the enrollment form provided by the County by which an Employee makes his benefits selection and by which the Employee may authorize the County to reduce his Compensation in order to obtain certain benefits. Such Election Form may include a telephonic enrollment, electronic transmission, online enrollment, or other non-paper method of transmission, as designated by the Plan Administrator.

1.12 Election Period means the period designated by the County, which precedes the beginning of each Plan Year, during which the Employee must complete his Election Form.

1.13 Elective Employer Contributions means contributions as described in Section 3.01.

1.14 Eligible Employee means an Employee who is eligible to participate in one or more of the programs offered under this Plan in accordance with the terms of Article II.

1.15 Employee means all active Employees of the Employer, other than Employees who are employed on a temporary basis.

1.16 Employer means Contra Costa County, Board of Supervisor governed Special Districts and other public bodies as authorized by ordinance or resolution of the Board of Supervisors of Contra Costa County.

1.17 FMLA means the Family and Medical Leave Act of 1993, as amended from time to time along with any pertinent Department of Labor regulations, rulings, notices or other promulgations.

1.18 Health Care Spending Account means the benefit as described in Article IX.

1.19 Health Plan means any of the health (medical, dental and/or vision care) plans, including any HMO or PPO plans, that are offered by the Employer excluding the Health Care Spending Account. All of these plans, are maintained in accordance with, and described in one or more documents that are not contained within this Plan document, but are incorporated by reference herein.

1.20 Health Savings Account (HSA) means the benefit as described in Article XII.

1.21 Highly Compensated Employee means those participants who are determined to be highly compensated under Code Section 414(q).

1.22 High Deductible Health Plan means a health plan that meets statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).

1.23 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time along with any pertinent Treasury or Department of Labor regulations, rulings, notices or other promulgations.

1.24 HMO means any of one or more health maintenance organizations that may be offering health benefits to eligible Employees, from time to time.

1.25 Key Employee means those participants who are determined to be key employees under Code Section 416(i)(1).

1.26 Participant means any Eligible Employee covered under this Plan who completes and delivers an Election Form to the County, as described in Article II.

1.27 PEMHCA means any one or more medical plans offered through the Public Employees' Medical and Hospital Act.

1.28 Plan means this Contra Costa County § 125 Benefits Plan.

1.29 Plan Administrator means the person or persons responsible for the administration of the Plan, as identified in Section 7.01.

1.30 Plan Year means the twelve (12) month period beginning each January 1 and ending December 31.

1.31 PPO means any of one or more preferred provider organizations that may be offering health benefits to Eligible Employees.

1.32 Premium Conversion Program means the portion of the Plan which allows Participants to elect to have pre-tax contributions made to fund their portion of Health Plan premiums, in accordance with Section 4.01.

1.33 Qualified Beneficiary means any person afforded rights of continued medical coverage under COBRA as a result of a Qualifying Event, as defined in COBRA and in the Health Plan plan document.

1.34 Spouse means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the Dependent Care Assistance Program, the term Spouse does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a qualified individual's (as defined in Section 10.05) principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half the cost of maintaining such household, and (iii) during the last six months of such taxable year, the individual is not a member of such household.

ARTICLE II

Eligibility Provisions

2.01 Eligible Employees. An Employee is an Eligible Employee under this Plan in accordance with the following rules:

(a) Premium Conversion Program. For purposes of premium conversion, any Employee who is in active pay status with the Employer shall be considered an Eligible Employee on the date on which he first becomes eligible to participate under one or more of the Health Plans, including medical, dental and/or vision, offered through the County.

(b) Dependent Care Assistance Program. For purposes of the Dependent Care Assistance Program, any permanent full-time Employee or permanent part-time Employee of the Employer shall be eligible to participate on the date on which he first becomes an Employee.

Permanent intermittent Employees shall not be eligible to participate in the Dependent Care Assistance Plan.

(c) Health Care Spending Account. For purposes of the Health Care Spending Account, any permanent full-time Employee or permanent part-time Employee who is regularly scheduled to work twenty (20) or more hours per week shall be eligible to participate on the date on which he first completes six (6) months as a permanent Employee.

Neither permanent part-time Employees who work less than twenty (20) hours per week nor permanent intermittent Employees shall be eligible to participate in the Health Care Spending Account.

(d) Health Savings Account. For the purposes of the Health Savings Account, any permanent full-time Employee or permanent part-time Employee who is regularly scheduled to work twenty (20) or more hours per week shall be eligible to participate on the date on which he first becomes an Employee. The Employee must also be enrolled in a qualifying High Deductible Health Plan.

(e) In addition to the above-referenced rules, participation under the Plan may commence in accordance with the details of an applicable Memorandum of Understanding between the County and one or more bargaining units.

2.02 Effective Date of Participation for Eligible Employees. To become a Participant, the Eligible Employee must first complete and deliver an Election Form to the County or to its authorized representative. For plans offered through the Public Employees' Medical

and Hospital Care Act (PEMHCA), participation begins on the first of the month coincident with or next following receipt of a properly completed election. For plans offered through other Health Plan providers, participation begins on the first of the month following completion of a thirty (30) day waiting period and receipt of a properly completed election.

2.03 Termination of Participation for Eligible Employees. Except as otherwise required by Article V, coverage with respect to a Participant shall end on the earliest of the following events:

(a) The date this Plan terminates;

(b) The date the Participant no longer has an election in effect under the terms of this Plan;

(c) The date the Participant ceases making the contributions required under the terms of the Plan;

(d) The last day of the month in which the individual ceases to be an Employee; or

(e) The end of the month following the last day in which the individual ceases to be an Employee for those enrolled in PEMHCA plans.

2.04 Termination of Benefit Plan Coverage. Coverage of any benefit plan option elected under this Plan shall terminate at the earlier of:

(a) The date so specified in the plan document of the respective benefit plan; or

(b) The end of each Plan Year.

Coverage for subsequent Plan Years can only be obtained in accordance with the election procedures set forth in Section 4.02.

2.05 COBRA Rights. Notwithstanding any provision to the contrary herein, nothing in this Article II shall affect the rights of a Qualified Beneficiary under COBRA.

2.06 Reenrollment

(a) In the case of an individual whose participation has ended in accordance with Section 2.03(b) or (c), such individual shall again be entitled to become a Participant on the next open enrollment date following the date on which he submits a completed Election Form.

(b) Subject to the restrictions of Section 125 of the Code, in the case of an individual whose participation has ended in accordance with Section 2.03(d), such individual shall again be entitled to become a Participant on the date he again becomes an

Eligible Employee. To again become a Participant, the Employee must complete and deliver an Election Form to the County or its authorized representative.

ARTICLE III

Contributions

3.01 Elective Employer Contributions. A Participant may elect to reduce his Compensation for a Plan Year and to use such amounts to purchase one or more of the various nontaxable benefit options offered under this Plan, including the Premium Conversion Plan options of medical, dental and/or vision, the Health Care Spending Account, ~~or~~ the Dependent Care Assistance Program, or the Health Savings Account. The monetary amount associated with this election constitutes Elective Employer Contributions. Such salary reduction shall be authorized by the Participant on an Election Form.

3.02 Pay Reduction and Payroll Withholding. A Participant's Compensation for a Plan Year shall be reduced by the amount of the Elective Employer Contributions that the Participant elects for the Plan Year under Section 3.01. Such contributions shall be made only by payroll reduction. At the end of each Participant's taxable year, however, those Participants who are Highly Compensated Employees with respect to such year will have the amount of the discriminatory excess, if any, as determined in the sole discretion of the County in accordance with the relevant provisions of the Code, added to such Participant's Compensation for purposes of reporting gross income to the Internal Revenue Service via Form W-2.

3.03 Maximum Amount of Elective Employer Contributions. The maximum amount of Elective Employer Contributions for any Plan Year may vary from Participant to Participant, and/or from year to year as determined under the Code.

3.04 Reduction of Certain Elections. The County shall have the power to partially reduce, or completely revoke, Elective Employer Contribution elections made by certain Participants in accordance with Section 3.01 of this Plan, at any time prior to or during a Plan Year, subject to the following:

(a) Reduction of Certain Elections to Prevent Discrimination. Notwithstanding any other provision of this Section, the Plan Administrator, at the direction of the County, may reduce or revoke an election of a Participant described below to the extent necessary to prevent this Plan from being considered discriminatory under Section 125(b), or 105(h)(2) or 129(d)(2) of the Code.

(1) In the case that such reduction affects health benefits, only the elections of Participants who are highly compensated as defined by either Section 105(h) or Section 125(e) of the Code may be reduced.

(2) In the case that such reduction affects other qualified benefits, only the elections of Participants who are highly compensated as defined in Section 125(e) of the Code, or are otherwise Key Employees as defined in Section 125(b) of the Code may be reduced.

(3) In the case that such reduction affects Dependent Care Assistance benefits, only the elections of Participants who are officers, owners, or highly compensated individuals as defined in Section 129(d) of the Code may be reduced.

(b) Reduction of Certain Elections Affecting Code Section 415. The County may reduce the amount of contributions made on behalf of any Participant to the extent it deems it necessary to enable any qualified retirement plan maintained by the Employer under Code Section 401 to comply with the limitation on annual additions as set forth in Code Section 415**.**

3.05 Forfeitures. Any forfeiture of Elective Employer Contributions shall be used by the County for any legitimate Plan purpose, including without limitation, payment of benefits under the Plan or the reasonable costs of administering the Plan.

ARTICLE IV

Participant Elections and Benefit Options

4.01 Benefit Options. Subject to all other provisions of this Plan, a Participant may choose between taxable cash or any of the following nontaxable benefits:

(a) Health Plan (varying coverage options).

(b) Health Care Spending Account (varying amounts).

(c) Dependent Care Assistance Program (varying amounts).

(d) Health Savings Account (varying amounts).

4.02 Election Procedures. Prior to the commencement of each Plan Year, the County shall provide an Election Forms and/or an Online Electronic Enrollment process to each Participant and to each other Employee who is eligible to become a Participant at the beginning of the Plan Year. Each Participant shall specify on the Election Forms the benefits described in Section 4.01 which are desired for the forthcoming Plan Year. Such Employee shall also agree to a reduction in his Compensation, if applicable, as provided in Article III. The elections made pursuant to the Election Forms shall be effective as of the first day of the Plan Year. Each Election Form must be completed and returned to the County on or before such date as the County shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Plan Year's elections will apply.

4.03 New Employees. If an Employee first becomes eligible to be a Participant under this Plan at some time other than at the beginning of a Plan Year, the County will provide such Employee with an Election Form and/or access to an Online Electronic Enrollment process. Such Employee may elect one or more of the benefits options described in this Article IV and so specify on the Election Forms. Such Employee shall also agree to a reduction in his Compensation, if applicable, as provided in Article III. The Election Form must be completed and returned to the County on or before such date as the County shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Plan Year's elections will apply.

4.04 Duration of Elections. Except as provided in Section 4.08, each Participant's election is irrevocable and shall remain in effect through the last day of the Plan Year, subject further to the conditions set forth in the plan document of the respective benefit plan.

4.05 Benefit Enrollment. Enrollment in any of the benefit plans offered under this Plan shall be governed by the terms, conditions and provisions of that plan's plan document.

4.06 Value of Benefits. The County shall determine and set the cost associated with each benefit offered under this Plan. Such cost can be changed at any time at the beginning of, or during, a Plan Year without prior notification to Participants or any Participating Employer.

4.07 Absence of Completed Election Form. Failure to return a completed Election Form to the County on or before the specified due date for the Plan Year in which an eligible Employee first becomes eligible to participate shall be considered a choice by the Employee to select cash only and to select no nontaxable Benefit Option. A Participant who fails to return an Election Form for any subsequent Plan Year shall be deemed to have selected cash only, except that with respect to any Health Plan, a Participant who fails to return an Election Form shall be deemed to have elected to continue whatever Health Plan he had selected on the most recent Election Form previously filed with the County; and shall further be treated as an agreement on the part of the Participant to reduce his Compensation by whatever amount is then necessary to purchase such Health Plan as provided in accordance with Article III of this Plan.

4.08 Change in Status Qualifying Event. A Participant may revoke his elections and make new elections with respect to the remainder of the Plan Year upon the occurrence of any of the following events and to the extent permitted under the Code:

(a) HIPAA Special Enrollment Rights. A Participant who qualifies for "special enrollment rights" as defined under HIPAA may revoke his elections under a Health Plan option and make a new election as corresponds with such rights, provided such election is made within the minimum time periods described by HIPAA.

(b) Change in Status. A Participant may revoke his elections and make new elections with respect to the remainder of the Plan Year if a change in status described in subsections i-v occurs; and the revocation and the new elections are on account of and consistent with a change in status, and only if such change is allowed under the terms of the respective benefit plan. The Participant must elect such change within thirty (30) days of the Change in Status event.

i. Legal Marital Status. Events that change the Participant's marital status including the following: marriage, divorce, death of Spouse, legal separation or annulment.
ii. Number of Dependents. Events that change a Participant's number of Dependents, including the following: birth, adoption, placement for adoption, and death.
iii. Employment Status. Any of the following events that change the employment status of the Participant, the Spouse, or Dependent; a termination or commencement of employment; change in employment status resulting in gaining or losing eligibility under the Plan; a commencement or return from an approved unpaid leave of absence; or a change in worksite.

iv. Dependent Satisfies or Ceases to Satisfy Eligibility. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to age, student status, or similar circumstances.

v. Residence. A change in the place of residence of the Participant, Spouse, or Dependent.

(c) FMLA Leave. A Participant, who takes a leave of absence under the FMLA, may revoke an existing election under a Health Plan option and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA, provided such election is made within the minimum time periods prescribed by FMLA.

(d) Health Plan Option Changes. In the event that a Health Plan option is significantly curtailed or eliminated during a Plan Year, each affected Participant may make a new election on a prospective basis for coverage under another Health Plan providing similar coverage. If a new Health Plan is made available to Participants during a Plan Year, Participants may revoke an existing election and make a new election under the new Health Plan option providing similar coverage.

If the cost of a Benefit Option increases or decreases, the County may require Participants to make a corresponding change in their elections for the remainder of the Plan Year. If a cost increase is significant, the County may in its sole discretion allow Participants to either make a corresponding prospective increase in their elections or to revoke such election and receive coverage under such alternate Benefit Options as may be specified by the County.

(e) Judgment, Decree or Order. A Participant may revoke his elections and make new elections with respect to the remainder of a Plan Year if both the revocation and the new election result from a change in the health plan coverage of an Employee's child as ordered by a Qualified Medical Child Support Order (as such term is defined in ERISA) or other court order resulting from divorce, legal separation, annulment or change in legal custody.

(f) Medicare or Medicaid. A Participant may revoke his elections and make new elections with respect to the remainder of a Plan Year if both the revocation and the new election result from the enrollment or disenrollment of an Employee, Spouse or Dependent either under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or under Title XIX of the Social Security Act (Medicaid).

(g) Purchase of a Qualified Health Plan. A Participant may revoke his elections and make new elections with respect to the remainder of a Plan Year if both the revocation and the new election result from the enrollment of an Employee,

Spouse or Dependent in a Qualified Health Plan purchased through a competitive marketplace recognized under the Patient Protection and Affordable Care Act.

(h) Benefit Plan Option. In the event that a Benefit Plan option is added during the Plan Year, each affected Participant may make a new election on a prospective basis.

Changes in contributions and benefits attributable to a change in the Participant's election shall be effective with respect to the pay period which begins coincident with or immediately following the date the new Election Form is accepted by the County.

ARTICLE V

COBRA Rights

5.01 In General. The health benefits provided under this Plan may be subject to COBRA. In the event any provision of this document is inconsistent with COBRA, the provisions of COBRA are applicable. A statement of COBRA rights under any Health Plan, if applicable, is contained in such plan's own plan document.

5.02 Definition of Employee and Participant. For purposes of COBRA, the terms Employee and Participant may include former Employees who have terminated employment with the County and persons who are current or former Dependent Spouses or Dependents of Employees. Accordingly, to the extent required by COBRA, any Qualified Beneficiary who has elected certain rights under COBRA shall be afforded privileges otherwise restricted to Participants, as defined in this Plan.

5.03 Enrollment Options. During open enrollment periods described in Section 4.02, a Participant who has election rights on account of his status as a Qualified Beneficiary shall be limited to electing prospective coverage under a Health Plan, unless other options are required by COBRA. Unless otherwise provided herein, no other plan or coverage presented in this Plan shall be available to anyone who is a Qualified Beneficiary.

ARTICLE VI

Amendment or Termination

6.01 Amendment or Termination. Except as provided herein, the Board of Supervisors reserves the right to amend or terminate this Plan at any time and in any manner. The Board may delegate this authority to any officer of the County. In the event of a termination of the Plan, all liabilities of the Plan shall be satisfied to the extent and as required by this plan document and any applicable law.

ARTICLE VII

Administration

7.01 Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall be the person, entity or committee appointed by the Board of Supervisors, with authority and responsibility to manage and direct the operation and administration of the Plan. Unless otherwise specified by the Board of Supervisors, the County Administrator or his duly authorized designee shall be the Plan Administrator.

It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

7.02 Powers and Duties. The Plan Administrator will have 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 will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To establish a funding policy and method consistent with the objectives of the Plan.

(b) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law.

(c) To interpret the Plan, its interpretation in good faith to be final and conclusive on all persons claiming benefits under the Plan.

(d) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan.

(e) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan.

(f) To allocate and delegate its 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 allocation, delegation or designation shall be set out in a written instrument executed by the Plan Administrator and the designated party.

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

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

Notwithstanding the provisions of this Section, the powers and duties allocated to the Plan Administrator and described in this section shall only be applicable with respect to a claim arising under any plan or to the administration of such plan to the extent that such power or duty is not allocated (either expressly or by implication) to the individual(s) or entity appointed to serve as administrator of such plan.

7.03 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 which 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 County.

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

7.05 Standard of Review. The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant or beneficiary is entitled to receive any benefit under the terms of this Plan, which interpretation shall be made by the Plan Administrator in its sole discretion. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review and shall be entitled to the maximum deference permitted by law.

ARTICLE VIII

Miscellaneous Provisions

8.01 Information to be Furnished. Participants shall provide the Plan Administrator with such information and evidence and shall sign such documents, as may reasonably be requested from time to time, for the purpose of administration of the Plan.

8.02 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the County or any Participating Employer, except as provided herein.

This Plan shall not be deemed to constitute a contract between the County and any Participant or to be a consideration of an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the County or to interfere with the right of the County to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

8.03 Governing Law. This Plan shall be construed, administered and enforced according to the laws of California except as may be preempted by federal law.

8.04 Facility of Payment. If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, death, illness or infirmity, mental incompetency or incapacity of any kind, the County may, in its discretion, direct the payment of such benefit:

(a) Directly to such person;

(b) To the legally appointed guardian or conservator of such person;

(c) To a relative, friend or institution for the comfort, support and maintenance of the person entitled to receive such amount, including without limitation, any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution caring for such person; or

(d) As directed by a court of competent jurisdiction.

The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any savings or commercial bank of the Plan Administrator's choice.

8.05 Lost Payee. Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward Employer contributions to the Plan. However, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable if a claim is made by the Participant or beneficiary. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

8.06 No Guarantee of Tax Consequences. Notwithstanding anything herein to the contrary, the County neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to 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 shall be the obligation of each Participant to notify the Plan Administrator if the Participant has reason to believe that any payment made or to be made to the Participant pursuant to the Plan is not excludable from the Participant's gross income for federal, state or local income tax purposes.

8.07 Funding. Payments due under the Plan will be made from the general assets of the Employer, and no funds will be escrowed or earmarked to pay benefits. Notwithstanding the immediately preceding sentence, different funding mechanisms may be used to provide benefits under any Health Plan or other Benefit Option in the County's sole discretion.

8.08 Indemnification of Employer by Participant. If a Participant receives one or more payments in accordance with applicable Plan provisions that are not for eligible dependent care expenses or eligible medical expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state or local income taxes or employment taxes from such payments. Such indemnification and reimbursement shall 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 such Compensation.

ARTICLE IX

Health Care Spending Account

9.01 Health Care Spending Account Authority. The benefit plan described in this Article IX is intended to qualify as a nontaxable Employee benefit under Section 105(b) of the Code, providing health care benefits to Participants and is to be interpreted in a manner consistent with the requirements of Section 105 of the Code.

9.02 Maximum Contributions. The maximum amount of Elective Employer Contributions that a Participant can elect to allocate to this benefit will be the maximum amount permissible under the Code for any Plan Year.

Except as may be permitted in accordance with the provisions of Section 9.04, the amount of Elective Employer Contributions for the Plan Year shall be contributed in a number of substantially equal installments throughout the Plan Year. The number of installments shall equal the number of pay periods in the Plan Year, or portion thereof, during which the eligible Employee is a Participant in this Health Care Spending Account. The installments shall be made coincident with the last day of each of the Participant's pay periods.

9.03 General Limitation on Benefits. The amount of reimbursement hereunder for any Plan Year to any Participant is limited to the amount of Eligible Expenses actually incurred by the Participant during such Plan Year and after the date he became a Participant. At no time may a Participant receive reimbursement of Eligible Expenses in excess of the amount scheduled to be credited to his Health Care Spending Account for such Plan Year, reduced by any prior payments to the Participant for such Plan Year.

Provided further, that no reimbursement shall be made to a Participant for an expense that is submitted for reimbursement after the March 31 following the end of the Plan Year.

9.04 Health Savings Accounts. Health Savings Account benefits cannot be elected with Health Care Spending Account benefits. If the Participant has elected to contribute to the Health Savings Account in Article XII of the Plan, then that Participant who is eligible for and elects to contribute to a Health Savings Account may not simultaneously participate in this Article.

9.04 Changes in Employee Elections. A Participant may revoke his Health Care Spending Account election and make a new Health Care Spending Account election with respect to the remainder of the Plan Year in accordance with the terms of Section 4.08 of this Plan and to the extent permissible under the Code.

Provided however, that in the event a Participant elects to change his Health Care Spending Account maximum amount during the Plan Year, such newly elected

maximum, reduced by the amount of prior reimbursements for that Plan Year, shall be applicable only to Eligible Expenses incurred after the date the change is effective.

9.05 Definitions. The following definitions shall apply for the purposes of this Article IX:

(a) Dependent means a Participant's dependent as defined in Section 105(b) of the Code.

(b) Eligible Expenses means any expense that meets all of the following requirements:

(1) It must be an expense for medical care as defined in Code Section 213(d).

The term "medical care" means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, and for transportation primarily for and essential to such medical care.

Provided, however, that insurance premiums shall not be an Eligible Expense under this Health Care Spending Account.

(2) It must be an expense incurred by either the Participant or his Spouse or Dependent.

(3) It must not be a reimbursable expense under any health plan other than this Health Care Spending Account.

(4) It must be incurred during a period of time during which the Employee was a Participant under this Plan and had elected to participate in this Health Care Spending Account plan, and must be incurred after the effective date of such election.

(5) It must be an expense with respect to which the Participant or his Spouse or Dependent has provided adequate substantiation.

For purposes of paragraph (4) above, an expense shall be deemed "incurred" as of the date the service is rendered or purchase is made from which the expense arises, regardless of when the Participant or his Dependent is actually billed or pays for the expense.

9.06 Time for Payments. A Participant may submit proof of payment for reimbursement consideration at any time. Reimbursement for the Participant's Eligible Expenses, however, will be made as soon as practical after complete documentation has been submitted by the Participant and approved by the Plan Administrator, but in any event, reimbursements shall be made not less frequently than monthly, but only to the extent the amount of the Participant's unreimbursed Eligible Expenses at that point in time exceeds

twenty dollars ($20.00). Notwithstanding the preceding, if Eligible Expenses of twenty dollars ($20.00) or less for any Plan Year remain unreimbursed on the March 31 immediately following the end of such Plan Year, the Participant will be reimbursed for the full amount of such expenses before any remaining balances are forfeited in accordance with Section 9.08.

9.07 Terminated Employees. Except as may otherwise be provided in Section 9.10, a Participant whose coverage under this Plan terminates during a Plan Year due to termination of employment or failure to satisfy the Plan's definition of an Employee may continue coverage under the Health Care Spending Account by making after-tax contribution installments as described in Section 9.02 in the form of timely, direct payments from the individual to the Health Care Spending Account, not by means of any payroll withholding, or other contribution made by the Employer on behalf of the Participant until the earliest of the following dates:

(a) The last day of the Plan Year.

(b) The date the individual elects to terminate coverage.

(c) The last day of the period for which the last contribution was paid by the individual.

An individual whose participation has terminated shall have until the March 31 following the end of the Plan Year to submit expenses for reimbursement consideration.

9.08 Forfeitures. Any balance attributable to Elective Employer Contributions for any given Plan Year that remains in a Participant's Health Care Spending Account on the day after the March 31 following the end of the Plan Year in which such contributions were made will be forfeited.

9.09 Mandatory Reduction of Contributions. The Plan Administrator, or any authorized representative operating on its behalf, retains the right to reduce any Participant's allocation of Elective Employer Contributions to this account in accordance with the terms of Section 3.04 of this Plan.

9.10 COBRA. The benefits provided under this Health Care Spending Account may be subject to COBRA. In the event any provision of this document is inconsistent with COBRA, the provisions of COBRA are applicable.

(a) Definition of Employee and Participant. For purposes of COBRA, the terms Employee and Participant may include former Employees who have terminated employment with the County and persons who are current or former dependent Spouses or dependents of Employees. Accordingly, to the extent required by COBRA, any Qualified Beneficiary who has elected certain rights under COBRA shall be afforded privileges otherwise restricted to Participants, as defined in Article I of this Plan.

(b) Continuation of Benefits. To the extent required by COBRA, rights under this Health Care Spending Account will continue for any Qualified Beneficiary beyond the date of normal termination of coverage, but not beyond the end of the Plan Year.

(c) Premiums. Contribution installments, as described in Section 9.02, made after the date the Qualified Beneficiary elected COBRA coverage shall be made in the form of timely, direct premium payments from the Beneficiary to the County, not by means of any Elective Employer Contributions. Such premiums shall be subject to the maximum surcharge permitted by COBRA.

(d) Other COBRA Provisions. Provisions concerning the length of COBRA benefits, COBRA election periods, and COBRA notification requirements, which apply to this Health Care Spending Account, shall be consistent with the minimum requirements imposed on this Health Care Spending Account by COBRA. No further rights shall be granted to a Qualified Beneficiary by this Plan.

9.11 Other Conditions. All other provisions of this document shall be applied to, and will govern with respect to, the Health Care Spending Account benefit plan, unless expressly contradicted by a provision within this Article IX or by a provision of any applicable law or regulation.

9.12 New Participants. Notwithstanding anything in Article III to the contrary, in the case of an Employee who first becomes a Participant after the first day of a Plan Year, the maximum amount of Elective Employer Contributions available to such Participant for the remainder of the Plan Year under this Health Care Spending Account shall be prorated. Provided that the rules of this Section do not alter the general requirements on the effective date of participation for Employees as set out in Section 2.01 of this Plan.

ARTICLE X

Dependent Care Assistance Program

10.01 Dependent Care Assistance Program Authority. The benefit plan described in this Article X is intended to qualify as a nontaxable Employee benefit under Section 129(a) of the Code, providing dependent care assistance benefits to Participants and is to be interpreted in a manner consistent with the requirements of Section 129.

10.02 Maximum Contributions. The maximum amount of Elective Employer Contributions that a Participant can elect to allocate to this benefit will be the maximum amount permissible under the Code for any Plan Year.

Except as may be permitted in accordance with the provisions of Section 10.04, the amount of Elective Employer Contributions for the Plan Year shall be contributed in a number of substantially equal installments throughout the Plan Year. The number of installments shall equal the number of pay periods in the Plan Year, or portion thereof, during which the eligible Employee is a Participant in this Dependent Care Assistance Program Account. The installments shall be made coincident with the last day of each of the Participant's pay periods.

10.03 General Limitations on Benefits. The amount of reimbursement hereunder in any Plan Year to any Participant is limited to the amount of Eligible Expenses actually incurred by the Participant during such Plan Year and after the date he became a Participant. At no time may a Participant receive reimbursement of Eligible Expenses in excess of the amount then standing to the credit of the Participant in his Dependent Care Assistance Program Account.

Provided further, that no reimbursement shall be made to a Participant for an expense that is submitted for reimbursement after the March 31 following the end of the Plan Year.

10.04 Changes in Employee Elections. A Participant may revoke his Dependent Care Assistance Program Account election and make a new Dependent Care Assistance Program Account election with respect to the remainder of the Plan Year in accordance with the terms of Section 4.08 of this Plan and to the extent permissible under the Code. Additionally, a change in the cost imposed by a dependent care provider who is not a relative of the Employee, as defined in Section 152(d)(2)(A) through (G) of the Code, or an event which causes a child to satisfy or cease to satisfy the definition of a "qualified individual" under Section 21(b) (1) of the Code will be considered a change in status.

In the event a Participant elects to change his Dependent Care Assistance Program Account maximum amount during the Plan Year, such newly elected maximum, reduced by the amount of prior reimbursements for that Plan Year, shall be applicable only to Eligible Expenses incurred after the date the change is effective.

10.05 Definitions, Only for Purposes of this Article X. The following definitions shall apply for the purposes of this Article X:

(a) Dependent means a "qualified individual" as defined in Section 21(b) (1) of the Code.

(b) Eligible Expenses means those expenses that meet each of the following requirements:

(1) Which are considered employment-related expenses defined in Section 21(b) (2) of the Code;

(2) Which are incurred by the Employee during a period of time during which he was a Participant under this Plan and had elected to participate in this Dependent Care Assistance Program, (regardless of when the Participant was actually billed or paid for the expense) and which are provided after the effective date of such election; and

(3) Which is an expense with respect to which the Participant has provided adequate substantiation.

10.06 Time for Payments. A Participant may submit proof of payment for reimbursement consideration at any time. Reimbursement for the Participant's Eligible Expenses, however, will be made as soon as practical after complete documentation has been submitted by the Participant and approved by the Plan Administrator, but in any event reimbursements shall be made not less frequently than monthly.

10.07 Terminated Employees. A Participant whose coverage under this Plan terminates during a Plan Year due to termination of employment or failure to satisfy the Plan's definition of an Employee will continue coverage under the Dependent Care Assistance Program by making contribution installments as described in Section 10.02 in the form of timely, direct payments from the individual to the Dependent Care Assistance Program Account, not by means of any payroll withholding, or other contribution made by the Employer on behalf of the Participant, until the earliest of the following dates:

(a) The last day of the Plan Year.

(b) The date the individual elects to terminate coverage.

(c) The last day of the period for which the last contribution was paid by the individual.

Notwithstanding the foregoing, the Plan Administrator, in its sole discretion, may waive the condition of continued installments on behalf of Participants who terminate employment during a Plan Year, and permit such an individual to continue to submit

expenses eligible for reimbursement to the extent such expenses do not exceed the balance credited to a Participant's Dependent Care Assistance Program Account at the time the expense is submitted for reimbursement. Any such waiver shall be made on a nondiscriminatory basis, treating all similarly situated Participants substantially alike.

An individual whose participation has terminated shall have until March 31 following the end of the Plan Year to submit expenses for reimbursement consideration.

10.08 Forfeitures. Any balance attributable to Elective Employer Contributions for any given Plan Year that remains in a Participant's Dependent Care Assistance Program Account on the day after the March 31 following the end of the Plan Year in which such contributions were made will be forfeited.

10.09 Mandatory Reduction of Contributions. The County, or any authorized representative operating on its behalf, retains the right to reduce any Participant's allocation of elected contributions to this account in accordance with the terms of Section 3.04 of this Plan.

10.10 Other Conditions. All other provisions of this document shall be applied to, and will govern with respect to, the Dependent Care Assistance Program Account benefit plan, unless expressly contradicted by a provision within this Article X or by a provision of any applicable law or regulation.

10.11 Statements. Subsequent to a reimbursement request, the Plan Administrator shall furnish each Participant who has elected to allocate any contribution to the Dependent Care Assistance Program, a written statement showing the amount of eligible dependent care expenses paid to the Participant in accordance with the applicable provisions of this Plan.

10.12 New Participants. Notwithstanding anything in Article III to the contrary, in the case of an Employee who first becomes a Participant after the first day of a Plan Year, the maximum amount of Elective Employer Contributions available to such Participant for the remainder of the Plan Year under this Dependent Care Spending Account shall not be prorated. Provided, that the rules of this Section do not alter the general requirements on the effective date of participation for Employees as set out in Section 2.01 of this Plan.

ARTICLE XI

Claims Procedure for Spending Accounts

11.01 Claims Filing Procedure. Claims with respect to a Participant's Health Care Spending Account or Dependent Care Assistance Program Account shall be submitted directly to the claims administrator on such forms as are prescribed by the claims administrator for filing proof of claim.

The claimant may be required to provide such other information as the claims administrator may deem necessary or appropriate for determining the validity of any claim.

11.02 Conditions on Benefits. A Participant, by electing to receive reimbursements under the Health Care Spending Account, shall be deemed to have warranted that each expense for which he seeks reimbursement qualifies for tax-free medical reimbursement under Section 105 of the Code. A Participant, by electing to receive dependent care assistance under the Plan, shall be deemed to have warranted that each expense for which he seeks reimbursement qualifies for tax-free dependent care assistance under Sections 129 and 21 of the Code.

Neither the County, nor the Plan Administrator, nor any third party administrator shall be responsible to investigate or determine the eligibility of such Participant to exclude such medical reimbursements or dependent care assistance from his taxable income. Each Participant shall be responsible for his portion of any additional federal, state or local income taxes or employment taxes owing in connection with any medical reimbursements or dependent care assistance paid under the Plan, and shall reimburse the County upon demand for any taxes assessed by reason of the County's failure to withhold such taxes (including any interest and penalties for the late payment thereof).

11.03 Payment of Claims. Upon submission of proof of a valid claim, any benefits shall be paid to the Participant in accordance with all relevant provisions of this Plan.

11.04 Denial of Claims. If a claim is denied in whole or in part, the claimant will be notified in writing by the County within ninety (90) days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of this extension will be sent to the claimant prior to the termination of the ninety (90) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a final decision. In no event will this date be more than ninety (90) days after the end of the initial ninety (90) day period.

The notice of the claim denial shall state (in a manner calculated to be understood by a claimant):

(a) The specific reason or reasons for the denial;

(b) Specific references to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

11.05 Claims Review Procedure. Within sixty (60) days after receiving written notice of claim denial, the claimant or his duly authorized representative may submit a written request for review to the County. When requesting a review, the claimant should state the reasons he believes the claim denial was improper and submit any additional information, material, issues or comments in writing which he considers appropriate. He or his duly authorized representative may also review any pertinent documents related to the claim.

The County will make a decision on the review within sixty (60) days after receipt of the request for review unless special circumstances require an extension of time for processing, in which case a decision will be made as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If such an extension is required, the claimant will be notified within sixty (60) days after receipt of the request for review.

The decision on the review will be in writing and will include the specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based. The decision by the County will be final.

ARTICLE XII

Health Savings Account

12.01 Health Savings Account Authority. The benefit described in this Article XII is intended to qualify as nontaxable under Section 223 of the Code and is to be interpreted in a manner consistent with the requirements of Section 223. A Participant can elect benefits under the Health Savings Account (HSA) portion of this Plan by electing to pay his or her HSA contributions on a pre-tax salary reduction basis. HSA benefits under this Plan consist solely of the ability to make contributions to an HSA on pre-tax salary reduction basis. The HSA is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Terms and conditions of benefits (e.g., eligible medical expenses and claims procedures) will be provided by and set forth in the HSA, not this Plan.

12.02 Enrollment in High Deductible Health Plan. To participate in the Health Savings Account, the Employee must also be enrolled in a County High Deductible Health Plan (HDHP).

12.03 Maximum Contributions. The maximum amount of Elective Employer Contributions that a Participant can elect to allocate to this benefit will be the maximum amount permissible under the Code for any Plan Year.

Except as may be permitted in accordance with the provisions of Section 12.04, the amount of Elective Employer Contributions for the Plan Year shall be contributed in a number of substantially equal installments throughout the Plan Year. The number of installments shall equal the number of pay periods in the Plan Year, or portion thereof, during which the eligible Employee is a Participant in this Health Savings Account. The installments shall be made coincident with the last day of each of the Participant's pay periods.

12.04 Changes in Employee Elections. A Participant may increase, decrease or revoke his Health Savings Account election and make a new Health Savings Account election with respect to the remainder of the Plan Year at any time during the Plan Year.

12.05 Health Care Spending Account. Health Care Spending Account benefits cannot be elected with Health Saving Account benefits. If the Participant has elected to contribute to the Health Care Spending Account in Article IX of the Plan, then that Participant who is eligible for and elects to contribute to a Health Care Spending Account may not simultaneously participate in this Article.

12.06 Mandatory Reduction of Contributions. The County, or any authorized representative operating on its behalf, retains the right to reduce any Participant's allocation of elected contributions to this account in accordance with the terms of Section 3.04 of this Plan.

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

12.08 Other Conditions. All other provisions of this document shall be applied to, and will govern with respect to, the Health Savings Account benefit plan, unless expressly contradicted by a provision within this Article XII or by a provision of any applicable law or regulation.

12.09 New Participants. Notwithstanding anything in Article III to the contrary, in the case of an Employee who first becomes a Participant after the first day of a Plan Year, the maximum amount of Elective Employer Contributions available to such Participant for the remainder of the Plan Year under this Health Savings Account shall not be prorated. Provided, that the rules of this Section do not alter the general requirements on the effective date of participation for Employees as set out in Section 2.01 of this Plan.

Article XIII

HIPAA Provisions for the Health Care Spending Account

13.01 Application. Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health Care Spending Account. When this health information is provided from the Health Care Spending Account 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.

13.02 Disclosure of PHI. The Health Care Spending Account will not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Article are met. "Protected Health Information" means information that is created or received by the Health Care Spending Account 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.

13.03 Permitted disclosure of enrollment/disenrollment information. The Health Care Spending Account may disclose to the Employer information on whether the individual is participating in the Plan.

13.04 Permitted uses and disclosure of summary health information. The Health Care Spending Account 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 Health Care Spending Account.
"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.

13.05 PHI disclosed for administrative purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 13.06 and obtaining written certification pursuant to Section 13.07, the Health Care Spending Account may disclose Protected Health Information to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health Care Spending Account, 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. Notwithstanding the provisions of this Plan to the contrary, in no event will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

13.06 PHI disclosed to certain workforce members. The Plan will disclose Protected Health Information for Plan administration purposes only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Health Care Spending Account. "Members of the Employer's workforce" refers to all employees and other persons under the control of the Employer. The Employer will allow the following members of the Employer's workforce to access to PHI: benefits staff, the Plan Administrator, and payroll staff performing Health Care Spending Account functions and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health Care Spending Account (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons will have access to PHI. The Employer will keep an updated list of those authorized to receive Protected Health Information.

(a) An authorized member of the Employer's workforce who receives Protected Health Information will use or disclose the Protected Health Information only to the extent necessary to perform the Plan administration functions that the Employer performs for the Health Care Spending Account.

(b) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Article and the Privacy Standards, the incident will be reported to the Plan's Privacy Official. The Privacy Official will take appropriate action, including:

(1) investigation of the incident to determine whether a breach occurred and if the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(3) mitigation of any harm caused by the breach, to the extent practicable; and

(4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

13.07 Certification. This provision constitutes certification by the Employer that it agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Health Care Spending Account or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Health Care Spending Account available to the Department of Health and Human Services for purposes of determining compliance by the Health Care Spending Account with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Health Care Spending Account that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, 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 Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in 13.06 above.

13.08 Privacy Official. The Employer will designate a Privacy Official, who will be responsible for the Plan’s compliance with HIPAA. The Privacy Official may contract with or

otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition and notwithstanding any provision of this Plan to the contrary, the Privacy Official will have the authority to and be responsible for:

(a) accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article;

(b) transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Employer;

(c) establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;

(d) establishing and overseeing proper training of personnel who will have access to PHI; and

(e) any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article.

13.09 Interpretation and Limited Applicability. This Article serves the sole purpose of complying with the requirements of HIPAA and will be interpreted and construed in a manner to effectuate this purpose. Neither this Article nor the duties, powers, responsibilities, and obligations listed therein will be taken into account in determining the amount or nature of the benefits provided to any person covered under the Health Care Spending Account, nor will they inure to the benefit of any third parties. To the extent that any of the provisions of this Article are no longer required by HIPAA or do not apply to the Plan because the Plan is otherwise excepted from HIPAA, they will be deemed deleted and will have no force or effect.

13.10 Breach Notification. Following the discovery of a breach of unsecured PHI, the Health Care Spending Account will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of the breach, in accordance with 45 CFR Section 164.404, and will notify the Department of Health and Human Services in accordance with 45 CFR Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Health Care Spending Account will notify the media in accordance with 45 CFR Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of technology or methodology specified in regulations or other guidance issued by the Department of Health and Human Services.

13.11 Compliance with HIPAA Electronic Security Standards. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) Implementation. The Employer agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" will have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information (other than enrollment or disenrollment information and Summary Health Information, which are not subject to these restrictions) that is transmitted by or maintained in electronic media.

(b) Agents or subcontractors will meet security standards. The Employer will ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information agrees, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) Employer will ensure security standards. The Employer will ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in this Article. The Employer will report to the Privacy Officer any security incident of which it becomes aware.

IN WITNESS WHEREOF, the County has caused this Plan to be executed in its name and behalf this _____ day of _____, 20___, by its representative thereunto duly authorized.

ATTEST (SEAL)

CONTRA COSTA COUNTY

_____

_____