



## AGENDA REPORT

**Meeting Date:** December 2, 2008  
**Item Number:** F-7  
**To:** Honorable Mayor & City Council  
**From:** Scott G. Miller, CFO  
**Subject:** **APPROVAL OF PROPOSED CAFETERIA PLAN**

**Attachments:**

1. City of Beverly Hills Cafeteria Plan
2. Health Care Flexible Spending Account
3. Dependent Care Flexible Spending Account
4. Benefit Plan Options
5. Claim Procedures

---

### **RECOMMENDATION**

Approve amended and restated flexible benefits plan (Cafeteria Plan) for the City of Beverly Hills full-time and regular part-time employees.

### **INTRODUCTION**

City staff has been working on enhancing the current flexible benefits plan for City employees by implementing a more robust cafeteria plan as well as exploring changes to the current employee benefits structure. Due diligence requires that the changes be carefully evaluated for compliance with governing Federal and State laws as well for long-term cost effectiveness. City staff has engaged HansonBridgitt a Benefits law firm as consultants to assist staff in its implementation.

### **DISCUSSION**

The City sponsors the City of Beverly Hills Cafeteria Plan, a "cafeteria plan" within the meaning of section 125 of the Internal Revenue Code. The plan is designed to provide certain welfare benefits to City employees on a pre-tax basis. The City originally adopted the plan on January 1, 2003. Working together with outside legal counsel, staff has prepared a "restatement" of the plan. If adopted, the restatement will replace the current version of the plan effective January 1, 2009. Generally, the restatement is designed to enable the City to contain health benefit costs, while providing a more

attractive and versatile benefit to eligible employees. Among other things, the restatement does the following:

1. conforms the plan's design to the City's desired benefit structure;
2. provides the City with maximum flexibility permitted under the tax rules over the types and amounts of pre-tax health benefits offered under the plan;
3. allows eligible employees to choose from a menu of health benefit options, enabling employees to tailor health benefit programs appropriate to their situation;
4. allows employees to receive additional City compensation in lieu of health benefits, subject to certain limitations that the City may impose;
5. updates the plan to conform to recent changes in the tax laws for cafeteria plans; and
6. simplifies and clarifies the plan's intended operation.

**FISCAL IMPACT**

No negative fiscal impact is anticipated. Funds are budgeted and available in Fiscal Year 2008-09.

  
\_\_\_\_\_  
Sandra Olivencia  
Human Resources Approval

  
\_\_\_\_\_  
Scott G. Miller  
Approved By

# ATTACHMENT 1

**CITY OF BEVERLY HILLS CAFETERIA PLAN**  
**Amended and Restated Effective January 1, 2009**

## TABLE OF CONTENTS

<b>PREAMBLE</b> .....	<b>1</b>
<b>ARTICLE I: DEFINITIONS</b> .....	<b>2</b>
1.01 "AFTER-TAX CONTRIBUTION(S)" .....	2
1.02 "ANNIVERSARY DATE" .....	2
1.03 "BENEFIT PLAN OPTION(S)" .....	2
1.04 "CHANGE IN STATUS" .....	2
1.05 "CITY COUNCIL" .....	2
1.06 "COBRA" .....	2
1.07 "CODE" .....	2
1.08 "COMPENSATION" .....	2
1.09 "DEPENDENT" .....	2
1.10 "DEPENDENT CARE FSA" .....	2
1.11 "EMPLOYEE" .....	2
1.12 "EMPLOYER" .....	3
1.13 "HEALTH CARE FSA" .....	3
1.14 "HIPAA" .....	3
1.15 "NONELECTIVE CONTRIBUTION(S)" .....	3
1.16 "PARTICIPANT" .....	3
1.17 "PERIOD OF COVERAGE" .....	3
1.18 "PLAN" .....	3
1.19 "PLAN ADMINISTRATOR" .....	3
1.20 "PLAN YEAR" .....	3
1.21 "PRE-TAX CONTRIBUTION(S)" .....	3
1.22 "QUALIFIED BENEFIT" .....	3
1.23 "REIMBURSEMENT ACCOUNT" .....	3
1.24 "SALARY REDUCTION AGREEMENT/ELECTION FORM" .....	4
1.25 "SPOUSE" .....	4
1.26 "STUDENT" .....	4
<b>ARTICLE II: ELIGIBILITY AND PARTICIPATION</b> .....	<b>4</b>
2.01 ELIGIBILITY TO PARTICIPATE .....	4
2.02 TERMINATION OF PARTICIPATION .....	4
2.03 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY .....	5
2.04 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT .....	5
2.05 NON-FMLA LEAVE .....	5
<b>ARTICLE III: METHOD AND TIMING OF ELECTIONS</b> .....	<b>5</b>
3.01 ELECTION OF CONTRIBUTIONS .....	5
3.02 INITIAL ELECTION PERIOD .....	5
3.03 ANNUAL ELECTION PERIOD .....	6
3.04 FAILURE TO MAKE AN ELECTION .....	6
3.05 CHANGE OF ELECTIONS .....	6
3.06 REDUCTION OF CERTAIN ELECTIONS TO PREVENT DISCRIMINATION .....	9
<b>ARTICLE IV: BENEFIT FUNDING</b> .....	<b>9</b>
4.01 SOURCE OF BENEFIT FUNDING .....	9

4.02	EMPLOYER CONTRIBUTIONS .....	9
<b>ARTICLE V: BENEFITS .....</b>		<b>10</b>
5.01	BENEFITS OFFERED .....	10
5.02	CASH OPTION .....	10
5.03	NO DEFERRED COMPENSATION .....	10
<b>ARTICLE VI: PLAN ADMINISTRATION .....</b>		<b>10</b>
6.01	ALLOCATION OF AUTHORITY .....	10
6.02	COMPENSATION OF PLAN ADMINISTRATOR.....	11
6.03	BONDING .....	11
6.04	PAYMENT OF ADMINISTRATIVE EXPENSES.....	11
6.05	INSURANCE CONTRACTS.....	11
<b>ARTICLE VII: CLAIM PROCEDURES .....</b>		<b>11</b>
<b>ARTICLE VIII: AMENDMENT OR TERMINATION OF PLAN .....</b>		<b>11</b>
8.01	NO VESTED RIGHTS .....	11
8.02	EMPLOYER'S RIGHT TO AMEND .....	12
8.03	EMPLOYER'S RIGHT TO TERMINATE .....	12
8.04	DETERMINATION OF EFFECTIVE DATE OF AMENDMENT OR TERMINATION .....	12
<b>ARTICLE IX: GENERAL PROVISIONS .....</b>		<b>12</b>
9.01	NOT AN EMPLOYMENT CONTRACT .....	12
9.02	APPLICABLE LAWS.....	12
9.03	REQUIREMENT FOR PROPER FORMS .....	12
9.04	MULTIPLE FUNCTIONS .....	12
9.05	TAX EFFECTS.....	12
9.06	CODE COMPLIANCE .....	12
9.07	HEADINGS.....	13
9.08	PLAN DOCUMENTS CONTROLLING .....	13
9.09	SEVERABILITY .....	13
9.10	EFFECT OF MISTAKE.....	13

## PREAMBLE

The City of Beverly Hills established the City of Beverly Hills Cafeteria Plan (the "Plan") effective January 1, 2003. The Plan was last restated effective January 1, 2006. The Plan is hereby amended and restated in its entirety, effective January 1, 2009. The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986 ("Code"), as amended, and is to be interpreted and administered in a manner consistent with Code Section 125 to permit eligible City employees to choose between taxable benefits in the form of cash compensation and nontaxable benefits from among the Benefit Plan Options listed in Appendix C.

The Plan permits pre-tax contributions, after-tax contributions, and nonelective employer contributions to pay for the Benefit Plan Options set out in Appendix C. The Plan also has two subparts: (1) a health care flexible spending account (the "Health Care FSA") attached as Appendix A, and (2) a dependent care flexible spending account (the "Dependent Care FSA") attached as Appendix B. The Health Care FSA allows eligible City employees to pay for certain medical care expenses on a pre-tax basis. The Dependent Care FSA allows eligible City employees to pay certain dependent care expenses on a pre-tax basis. The Plan's claim procedures are set out in Appendix D.

## CITY OF BEVERLY HILLS CAFETERIA PLAN

### ARTICLE I DEFINITIONS

Capitalized terms used in this Plan that are not otherwise defined have the meanings set forth below.

**1.01 "After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement/Election Form after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan.

**1.02 "Anniversary Date"** means the first day of any Plan Year.

**1.03 "Benefit Plan Option(s)"** means those Qualified Benefits available to a Participant under this Plan as set forth in Appendix C, as amended from time to time.

**1.04 "Change in Status"** means any of the events described in Section 3.05(a), as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change an election mid-year.

**1.05 "City Council"** means the governing body of the Employer.

**1.06 "COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

**1.08 "Compensation"** means the cash wages or salary paid to an Employee by the Employer.

**1.09 "Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a); however, in the case of health benefits, a Dependent is defined as set forth in Code Section 105(b) and the regulations issued under Code Section 106.

**1.10 "Dependent Care FSA"** means the Dependent Care Flexible Spending Account component of this Plan described in Appendix B.

**1.11 "Employee"** means an individual who is classified by the Employer as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code Section 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or (e) any employee covered under a collective bargaining agreement, unless that agreement provides the employee's participation in this Plan.

- 1.12 "Employer"** means the City of Beverly Hills.
- 1.13 "Health Care FSA"** means the Health Care Flexible Spending Account component of this Plan described in Appendix A.
- 1.14 "HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.
- 1.15 "Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute under the Plan to provide benefits for individual Participants and their Spouses, Dependents, domestic partners, and same-sex spouses, as applicable, under one or more of the Benefit Plan Options offered under the Plan.
- 1.16 "Participant"** means an Employee who becomes a Participant pursuant to Article II.
- 1.17 "Period of Coverage"** means the Plan Year, with the following exceptions: (1) for Employees who first become eligible to participate mid-Plan year, it means the portion of the Plan Year following the date on which the Employee's participation commences; and (2) for Employees who terminate participation, it means the portion of the Plan Year prior to the date on which the Employee's participation terminates.
- 1.18 "Plan"** means this City of Beverly Hills Cafeteria Plan, including all appendices, as amended from time to time.
- 1.19 "Plan Administrator"** means the person(s), entity, or committee appointed by the City Council with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person or committee is appointed, the Plan Administrator is the Employer.
- 1.20 "Plan Year"** means the calendar year (January 1st through December 31st).
- 1.21 "Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement/Election Form before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan. This amount will be treated as an employer contribution for purposes of Code Section 125.
- 1.22 "Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Code Sections 106(b), 117, 124, 127, or 132, and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79). Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."
- 1.23 "Reimbursement Account"** means an account established for each Participant under the Health Care FSA and/or the Dependent Care FSA. No money will actually be allocated to any individual Participant's Reimbursement Account(s). A Reimbursement Account will be a bookkeeping entry to record amounts withheld from an Employee's Compensation for reimbursement of eligible expenses. The Reimbursement Account will be maintained by the Plan Administrator for accounting purposes and will not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to a Participant's Reimbursement Account.

**1.24 "Salary Reduction Agreement/Election Form"** means the actual or deemed agreement and election form by which an eligible Employee or Participant may, to the extent permitted by the Plan Administrator, elect (1) one or more Benefit Plan Options under this Plan and agrees to contribute his or her share of the cost, if any, of chosen Benefit Plan Options with Pre-tax Contributions, After-tax Contributions and/or Nonelective Contributions (if offered under the Plan) in accordance with Article III herein, and (2) to participate in and make salary reduction contributions under the Health Care FSA or the Dependent Care FSA, or both. If the Employer utilizes an interactive voice response (NR) system or web-based program for enrollment, the Salary Reduction Agreement/Election Form may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

**1.25 "Spouse"** means an individual who is legally married to a Participant, and who is treated as a spouse under the Code.

**1.26 "Student"** means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

## **ARTICLE II ELIGIBILITY AND PARTICIPATION**

**2.01 Eligibility to Participate.** Each Employee who is eligible for coverage or participation under any of the Benefit Plan Options will become a Participant in this Plan on the date he or she becomes an Employee. As a Participant, the Employee will be permitted to (1) allocate available Nonelective Contributions toward the Benefit Plan Options for which he or she is eligible in the manner set forth in the enrollment materials, and (2) contribute his or her share of the cost with Pre-tax Contributions (or After-Tax Contributions to the extent permitted by the Employer, if at all). The provisions of this Article are not intended to override any eligibility requirement or waiting period specified in the applicable Benefit Plan Options and the terms of eligibility and participation for any Benefit Plan Option offered under the Plan are subject to the requirements specified in the governing documents of the Benefit Plan Option.

**2.02 Termination of Participation.** A Participant's participation in the Plan will terminate on the earliest of the following dates.

- a) the date the Participant makes a permitted election not to participate in the Plan;
- b) the date that the Participant no longer satisfies the eligibility requirements of this Plan or all of the Benefit Plan Options;
- c) the date the Participant's employment with the Employer terminates; or
- d) the date that the Plan is either terminated or amended to exclude the Participant or the class of employees to which the Participant belongs.

Termination of participation in this Plan will automatically revoke the Participant's Salary Reduction Agreement/Election Form. If revocation occurs under this Section 2.02, no new election may be made by such Participant during the remainder of the Plan Year except as set forth in Section 2.03.

### **2.03 Participation Following Termination of Employment or Loss of Eligibility.**

A former Participant who is rehired or becomes eligible again more than 30 days after the Participant's termination of employment or loss of eligibility may make new elections (subject to any limitations imposed by the Benefit Plan Option(s)). If a Participant's employment with the Employer terminates for any reason and the Participant is then rehired within 30 days or less after the termination date, or if a Participant again becomes eligible within 30 days or less after a loss of eligibility, then the same elections that were in effect at the time the individual terminated employment or lost eligibility will be reinstated and will remain in effect for the remainder of the Plan Year (subject to any limitations imposed by the Benefit Plan Option(s) and unless the Participant is allowed to change his or her election under Section 3.05).

**2.04 Qualifying Leave Under Family Leave Act.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plan Options that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage during an FMLA leave, the procedures that apply to FMLA leave under the Plan and the payment option(s) permitted by the Employer will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA. The Employer will apply any requirements regarding a leave of absence under the Plan to all Participants on a uniform and consistent basis in accordance with the Employer's internal policies and procedures.

**2.05 Non-FMLA Leave.** If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plan Options chosen by the Participant, then the Participant will continue to participate and the Participant must pay contributions due by using one or more of the payment options permitted by the Employer. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plan Options chosen by the Participant, the election change rules in Section 3.05 will apply. If the Employer's policy requires coverage to continue during the leave, but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

## **ARTICLE III METHOD AND TIMING OF ELECTIONS**

**3.01 Election of Contributions.** A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (to the extent permitted by the Employer) to fund any Benefit Plan Option available under the Plan. If the Employer makes Nonelective Contributions on behalf of a Participant, the Employer may, but is not required to, allocate all or some portion of the Nonelective Contributions to one or more Benefit Plan Options offered under the Plan. The Employer may also allow the Participant to choose the allocation. The manner in which Nonelective Contributions may be allocated under the Plan will be set forth in the enrollment materials.

**3.02 Initial Election Period.** An Employee who becomes eligible to participate in the Plan mid-year will be permitted, during an initial election period as set forth in the enrollment materials, to sign and file a Salary Reduction Agreement/Election Form with the Plan Administrator (or its designated third-party administrator as set forth on the Salary Reduction Agreement/Election Form). Coverage will commence under this Plan on the date the Employee

becomes a Participant. Coverage under the component Benefit Plan Options will be effective in accordance with the governing provisions of such Benefit Plan Options.

**3.03 Annual Election Period.** Each Employee who is a Participant or who is eligible to become a Participant will be notified, prior to each Anniversary Date, of his or her right to become a Participant, to continue participation in this Plan, or to modify or to cease participation in this Plan, as applicable, and will be given a reasonable period of time in which to exercise such right. The date on which such annual election period begins and ends will be set forth in the enrollment materials. The election a Participant makes during an annual election period will be effective the first day of the next Plan Year and cannot be changed during the entire Plan Year, except as provided under Section 3.05.

**3.04 Failure to Make an Election.** A new Participant's failure to make an election under Section 3.02 on or before the due date specified by the Plan Administrator for the Plan Year in which he or she becomes a Participant will constitute a "default election" as determined by the Plan Administrator. If the Participant fails to make an election under Section 3.03 during an annual election period, the Participant will be deemed to have elected to continue participation in the Plan with the same Benefit Plan Options that the Participant had on the last day of the Plan Year in which the annual election period occurred (adjusted to reflect any increase/decrease in applicable premiums/contributions).

Notwithstanding the foregoing, no default elections or deemed elections apply to Reimbursement Accounts. A Participant must make an election on a Salary Reduction Agreement/Election Form during the Participant's initial election period and each annual election period to participate in the Reimbursement Accounts during the applicable Plan Year.

**3.05 Change of Elections.** A Participant may not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except during the annual election period and under the circumstances set forth in this Section 3.05 to the extent permitted by the Plan Administrator in its sole discretion. A Participant may also make election changes caused by termination of employment or cessation of eligibility, and election changes pursuant to the Family and Medical Leave Act. Except for special enrollment rights under Section 3.05(b) arising from the birth, adoption, or placement for adoption of a child, all election changes will be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed). As determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later. Election changes that are not permitted under a Benefit Plan Option will not be permitted under this Plan. A Participant must file an election change within 30 days after the occurrence of the event causing the change.

- a) **Change in Status.** Election changes may be allowed if a Participant or a Participant's Spouse or Dependent experiences any of the Change in Status events set forth below. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator (or its designated third-party administrator). As a general rule, an election change will be consistent with a Change in Status event if the Change in Status affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan.

(i) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, annulment, or legal separation.

(ii) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, or placement for adoption.

(iii) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; or (5) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan.

(iv) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance.

(v) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

In addition, a Participant must also satisfy the following specific requirements to alter his or her election based on that Change in Status:

*Loss of Spouse or Dependent Eligibility.* For a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel accident or health benefits for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. A Participant may only cancel accident or health coverage for the affected Spouse or Dependent. The Plan Administrator may permit a Participant to increase Pre-tax Contributions to pay for COBRA coverage of a Dependent.

*Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in the Participant's, the Participant's Spouse's, or the Participant's Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

*Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan).* For group term life insurance, disability income and accidental death and dismemberment benefits, an election to either increase or decrease coverage is permitted only if a Participant experiences a Change in Status (as described above).

b) **Special Enrollment Rights.** If a Participant or his or her Spouse or Dependent are entitled to HIPAA special enrollment rights under a Benefit Plan Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. As required by HIPAA, a special enrollment right arises in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because (i) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (ii) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or
- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child is considered to be consistent with the special enrollment right. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

c) **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or legal custody change requires a Dependent child (including a foster child who is a Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as a Participant's former Spouse) cover the Dependent child, and such coverage is actually provided, the Participant may change his or her election to revoke coverage for the Dependent child.

d) **Entitlement to Medicare or Medicaid.** If a Participant or his or her Spouse or Dependent becomes entitled to Medicare or Medicaid, an election to cancel that individual's accident or health coverage is permitted. Similarly, if a Participant or Participant's Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may elect to begin or increase that individual's accident or health coverage.

e) **Change in Cost.** If the cost of a Benefit Plan Option significantly increases, a Participant may choose either to make an increase in contributions, revoke the election and receive coverage under another Benefit Plan Option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Benefit Plan Option significantly decreases, a Participant who elected to participate in another Benefit Plan Option may revoke the election and elect to receive coverage provided under the Benefit Plan Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Plan Option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Plan Options, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator in its sole discretion and on a uniform and consistent basis will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances. The Plan Administrator will have final authority to determine whether the requirements of this Section 3.05(e) are met.

- f) **Change in Coverage.** If coverage under a Benefit Plan Option is significantly curtailed, a Participant may elect to revoke his or her election and elect coverage under another Benefit Plan Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change as permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, a Participant may change his or her election to add coverage under this Plan for the Participant, or the Participant's Spouse or Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator in its sole discretion and on a uniform and consistent basis will determine whether the requirements of this Section 3.05(f) are met.

**3.06 Reduction of Certain Elections to Prevent Discrimination.** If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on contributions allocable to any Participant or class of Participants, the Plan Administrator will take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Participant's or a class of Participants' elections without the consent of such Participants.

#### **ARTICLE IV BENEFIT FUNDING**

**4.01 Source of Benefit Funding.** The cost of coverage under the component Benefit Plan Options will be funded by a Participant's Pre-tax or After-tax Contributions, or by Nonelective Contributions provided by the Employer, or a combination of the foregoing. The required contributions for each of the Benefit Plan Options offered under the Plan will be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the Salary Reduction Agreement/Election Form and permitted by the Employer) that are allocated to any Benefit Plan Option will equal the contributions required from the Participant less any available Nonelective Contributions allocated to that option. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions will be applied to fund benefits as soon as administratively feasible. The maximum amount of employee contributions, plus any Nonelective Contributions made available by the Employer, will not exceed the aggregate cost of the Benefit Plan Options elected.

**4.02 Employer Contributions.** The Employer may, in its sole discretion, make Nonelective Contributions on behalf of a Participant toward the cost of one or more Benefit Plan Options. The amount of Nonelective Contributions that may be applied towards the cost of each of the Benefit Plan Option(s) for any Participant will be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the Employer's sole discretion. The amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer may

prescribe. To the extent set forth in the enrollment materials, Participants may allocate Nonelective Contributions among the various Benefit Plan Options offered under the Plan.

## **ARTICLE V BENEFITS**

**5.01 Benefits Offered.** Each Participant may choose under this Plan to receive cash compensation, or one or more Benefit Plan Options available to the Participant, or any combination of the foregoing as provided in the enrollment materials. The Benefit Plan Options available under the Plan for any Plan Year are specified in Appendix C, as amended from time to time. The maximum benefit a Participant may elect under this Plan may not exceed the sum of the aggregate maximum premium and/or contribution for all Benefit Plan Option(s) set forth in Appendix C.

**5.02 Cash Option.** To the extent that a Participant does not elect to have the maximum amount of his or her Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected will be paid to the Participant in the form of normal Compensation payments. A Participant may not receive applicable Nonelective Contributions in the form of cash compensation except as otherwise permitted by the Employer in its sole discretion and as provided in the enrollment materials. The Participant's ability to receive a Nonelective Contribution as cash compensation may be subject to any conditions imposed by the Employer, including a requirement that the Participant submit proof of other health coverage in order to elect cash in lieu of a Benefit Plan Option.

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

## **ARTICLE VI PLAN ADMINISTRATION**

**6.01 Allocation of Authority.** The City Council may appoint a Plan Administrator that keeps the records for the Plan and that will control and manage the operation and administration of the Plan. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan. All determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding on all persons. Without limiting the foregoing, the Plan Administrator has the following powers and duties:

- a) to require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

- b) to make and enforce such rules, procedures, and regulations and prescribe the use of such forms as it deems necessary for the efficient administration of the Plan;
- c) to decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;
- d) to designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan (in which case, such entity will be referred to as a third-party administrator);
- e) to keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan; and
- f) to do all things necessary to operate and administer the Plan in accordance with provisions of the Plan.

**6.02 Compensation of Plan Administrator.** Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer will serve without additional compensation for services rendered in such capacity, but the Employer will pay all reasonable expenses incurred in the performance of the Plan Administrator's duties.

**6.03 Bonding.** Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator will not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

**6.04 Payment of Administrative Expenses.** The Employer currently pays all reasonable expenses incurred in administering the Plan.

**6.05 Insurance Contracts.** The Employer has the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefit Plan Options offered under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of, and will be retained by, the Employer.

## **ARTICLE VII CLAIM PROCEDURES**

The Plan has established procedures for reviewing claims denied under this Plan. The procedures are set forth in Appendix D.

## **ARTICLE VIII AMENDMENT OR TERMINATION OF PLAN**

**8.01 No Vested Rights.** The Employer may at any time amend or terminate the Plan as provided in Sections 8.02 and 8.03 below. Nothing in this Plan is intended to or will be construed to entitle any Participant or other person to vested or non-terminable benefits.

**8.02 Employer's Right to Amend.** The Employer reserves the right to amend at any time any or all of the provisions of the Plan. The City Manager and the Chief Financial Officer of the City of Beverly Hills have the power to adopt Plan amendments. All amendments must be in writing and must be executed by the City Manager or Chief Financial Officer of the City of Beverly Hills. Each Benefit Plan Option will be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section.

**8.03 Employer's Right to Terminate.** The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan will be made in writing and must be approved by the City Council or authorized officer of the Employer.

**8.04 Determination of Effective Date of Amendment or Termination.** Any such amendment, discontinuance or termination will be effective as of the date the Employer determines.

## **ARTICLE IX GENERAL PROVISIONS**

**9.01 Not an Employment Contract.** Neither this Plan nor any action taken with respect to it confers upon any person the right to continued employment or service with the Employer in any capacity.

**9.02 Applicable Laws.** The provisions of the Plan will be construed, administered and enforced according to applicable federal law and, to the extent not preempted, the laws of the State of California.

**9.03 Requirement for Proper Forms.** All communications in connection with the Plan made by a Participant will become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

**9.04 Multiple Functions.** Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

**9.05 Tax Effects.** Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Contributions by any Participant will be treated as excludable from gross income for federal or state income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or beneficiary is includable in an Employee's gross income for federal or state income tax purposes, then under no circumstances will the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employee as a result thereof.

**9.06 Code Compliance.** The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code. It is intended that this Plan meet all applicable requirements of the Code and regulations issued thereunder. This Plan will be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict.

**9.07 Headings.** The Article and Section headings in the Plan are for convenience of reference only, and do not define or limit the matter contained in the Plan.

**9.08 Plan Documents Controlling.** The actual terms and conditions of the separate component Benefit Plan Options offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and this Plan as to substantive content.

**9.09 Severability.** If a court of competent jurisdiction invalidates any part of this Plan, the remainder thereof will be given effect to the maximum extent possible.

**9.10 Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer (to the extent permitted by applicable law).

**IN WITNESS WHEREOF**, the Employer has executed this Plan on this \_\_\_\_\_ day of \_\_\_\_\_, 2008.

CITY OF BEVERLY HILLS

By: \_\_\_\_\_

Title: \_\_\_\_\_

# ATTACHMENT 2

## **HEALTH CARE FLEXIBLE SPENDING ACCOUNT APPENDIX A TO THE CITY OF BEVERLY HILLS CAFETERIA PLAN**

**Amended and Restated Effective January 1, 2009**

**TABLE OF CONTENTS**

**PREAMBLE** ..... 1

**ARTICLE IA: DEFINITIONS**.....2

    1.01A "DEPENDENT" .....2

    1.02A "ELIGIBLE MEDICAL EXPENSE(S)" .....2

    1.03A "HEALTH CARE FSA" .....2

    1.04A "PARTICIPANT" .....2

    1.05A "REIMBURSEMENT ACCOUNT" .....2

**ARTICLE IIA: ELIGIBILITY AND PARTICIPATION**.....2

    2.01A ELIGIBILITY TO PARTICIPATE .....2

    2.02A TERMINATION OF PARTICIPATION.....2

    2.03A PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF  
         ELIGIBILITY .....3

**ARTICLE IIIA: ELECTION TO PARTICIPATE** .....3

    3.01A INITIAL ELECTION PERIOD .....3

    3.02A ANNUAL ELECTION PERIOD.....3

    3.03A CHANGE OF ELECTIONS .....4

    3.04A REDUCTION OF CERTAIN ELECTIONS TO PREVENT DISCRIMINATION .....4

**ARTICLE IVA: CONTRIBUTIONS AND REIMBURSEMENTS** .....4

    4.01A CONTRIBUTIONS.....4

    4.02A HEALTH CARE REIMBURSEMENT .....4

    4.03A GRACE PERIOD .....5

    4.04A RUN OUT PERIOD.....5

    4.05A RECEIVING HEALTH CARE REIMBURSEMENT .....5

    4.06A SUBSTANTIATION OF EXPENSES .....5

    4.07A REPAYMENT OF EXCESS REIMBURSEMENTS .....6

    4.08A REIMBURSEMENT FOLLOWING CESSATION OF PARTICIPATION.....6

    4.09A COORDINATION OF BENEFITS UNDER THE HEALTH CARE FSA.....7

    4.10A DISBURSEMENT REPORTS .....7

    4.11A TIMING OF REIMBURSEMENTS .....7

    4.12A NON-ALIENATION OF BENEFITS .....7

    4.13A MENTAL OR PHYSICAL INCOMPETENCY .....7

    4.14A INABILITY TO LOCATE PAYEE.....7

    4.15A TAX EFFECTS OF REIMBURSEMENTS .....7

    4.16A FORFEITURE OF UNCLAIMED REIMBURSEMENT ACCOUNT BENEFITS.....7

**ARTICLE VA: FUNDING AGENT** .....8

**ARTICLE VIA: CLAIM PROCEDURES**.....8

**ARTICLE VIIA: CONTINUATION COVERAGE UNDER COBRA** .....8

**ARTICLE VIIIA: HIPAA PRIVACY AND SECURITY** .....8

    8.01A SCOPE AND PURPOSE .....8

    8.02A EFFECTIVE DATE.....8

    8.03A USE AND DISCLOSURE OF PHI .....9

    8.04A CONDITIONS IMPOSED ON EMPLOYER.....9

    8.05A DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI .....10

**TABLE OF CONTENTS**

(continued)

8.06A RESTRICTIONS ON EMPLOYEES WITH ACCESS TO PHI ..... 10  
8.07A POLICIES AND PROCEDURES ..... 10  
8.08A ORGANIZED HEALTH CARE ARRANGEMENT ..... 10  
8.09A PRIVACY OFFICIAL ..... 10  
8.10A NONCOMPLIANCE ..... 11  
8.11A DEFINITIONS ..... 11  
8.12A INTERPRETATION AND LIMITED APPLICABILITY ..... 11  
8.13A SERVICES PERFORMED FOR THE EMPLOYER ..... 11

## **PREAMBLE**

The City of Beverly Hills established this Health Care Flexible Spending Account (the "Health Care FSA") effective January 1, 2003, for the benefit of employees who are covered by the City of Beverly Hills Cafeteria Plan ("Plan" or "Cafeteria Plan"), and who choose to contribute to a Health Care FSA Reimbursement Account established under this Health Care FSA. This Health Care FSA was last amended and restated effective as of January 1, 2006. It is hereby amended and restated in its entirety, effective January 1, 2009.

This Health Care FSA is intended to provide reimbursement of certain eligible medical expenses incurred by the Participant and his or her eligible spouse and dependents. The Employer intends that the Health Care FSA qualify as a self-insured medical reimbursement plan under Section 105 of the Internal Revenue Code, as amended ("Code"), and that the benefits provided under the Health Care FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code. This Health Care FSA is a component of, and incorporated by reference into, the Cafeteria Plan, and Articles VI, VII, VIII and IX of the Cafeteria Plan document apply also to this Health Care FSA.

## **ARTICLE IA DEFINITIONS**

Unless otherwise specified, capitalized terms in this Appendix A have the same meaning as the defined terms in the Cafeteria Plan. The definitions of terms defined in this Appendix A, but not defined in the Cafeteria Plan, are only applicable with respect to this Appendix A. If a term is defined both in the Cafeteria Plan and in this Appendix A, the definition in this Appendix A applies.

**1.01A "Dependent"** means any individual who is a tax dependent of the Participant as defined in Code Section 105(b).

**1.02A "Eligible Medical Expense(s)"** means an expense incurred by a Participant or his or her eligible Spouse or Dependents for "medical care" as defined under Code Section 213(d) and that has not been and will not be reimbursed by any other source. An Eligible Medical Expense does not include health insurance premiums or expenses incurred for qualified long term care services. Eligible Medical Expenses are eligible for reimbursement under this Health Care FSA.

**1.03A "Health Care FSA"** means this Health Care Flexible Spending Account, as amended from time to time.

**1.04A "Participant"** means a person who has met the eligibility requirements under Section 2.01A, elected to participate in accordance with that section, and whose participation has not terminated under Section 2.02A.

**1.05A "Reimbursement Account"** is the bookkeeping entry to record amounts withheld from a Participant's Compensation and that are available for a future reimbursement of a Participant's Eligible Medical Expense. No money will actually be allocated to or held under any individual Participant's account. A Reimbursement Account will be maintained by the Plan Administrator for accounting purposes, and will not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant's Reimbursement Account.

## **ARTICLE IIA ELIGIBILITY AND PARTICIPATION**

**2.01A Eligibility to Participate.** Each Employee is eligible to participate in the Health Care FSA on the date he or she becomes an Employee. The Employee's commencement of participation in the Health Care FSA is conditioned on the Employee properly completing a Salary Reduction Agreement/Election Form and submitting it to the Plan Administrator during the applicable election period under Section 3.01A or 3.02A.

**2.02A Termination of Participation.** A Participant's participation in the Health Care FSA will terminate on the earliest of the following dates:

- a. the date the Participant makes a permitted election not to participate in the Health Care FSA;
- b. the last day of the Plan Year unless the Participant elects to continue to participate in the next Plan Year;

- c. the date that the Participant no longer satisfies the eligibility requirements of the Health Care FSA;
- d. the date the Participant's employment with the Employer terminates; or
- e. the date that the Health Care FSA is either terminated or amended to exclude the Participant or the class of employees to which the Participant belongs.

Termination of employment or cessation of eligibility will automatically revoke any Salary Reduction Agreement/Election Form. If revocation occurs under this Section 2.02A, no new election with respect to the Health Care FSA may be made during the remainder of the Plan Year except as set forth in Section 2.03A. A Participant and his or her Spouse and covered Dependents may be entitled to COBRA coverage in accordance with Article VIIA if coverage under this Health Care FSA is lost because of a COBRA qualifying event.

### **2.03A Participation Following Termination of Employment or Loss of Eligibility.**

If a former Participant is rehired as an eligible Employee or becomes eligible again more than 30 days after the Participant's termination of employment or loss of eligibility, he or she may make new elections under the Health Care FSA. If a Participant's employment with the Employer terminates and the Participant is rehired as an eligible Employee within 30 days or less after the termination date, or if a Participant again becomes eligible within 30 days or less after a loss of eligibility, the same elections that were in effect at the time the individual terminated employment or lost eligibility will be reinstated and will remain in effect for the remainder of the Plan Year (unless the Participant changes his or her election as permitted under Section 3.03A).

## **ARTICLE IIIA ELECTION TO PARTICIPATE**

**3.01A Initial Election Period.** To become a Participant, an Employee who first becomes eligible to participate in this Health Care FSA mid-year must complete, sign and file a Salary Reduction Agreement/Election Form with the Plan Administrator (or its designated third-party administrator as set forth on the Salary Reduction Agreement/Election Form) during the initial election period set forth in the enrollment materials. Participation will commence under this Health Care FSA on the date the Participant files a properly completed Salary Reduction Agreement/Election Form with the Plan Administrator (or its designated third-party administrator) or on such later date specified by the Plan Administrator. An eligible Employee who does not submit a signed Salary Reduction Agreement/Election Form in accordance with this Section 3.01A during an initial election period may become a Participant on a later date in accordance with Section 3.02A or 3.03A.

**3.02A Annual Election Period.** Each Employee who is a Participant or who is eligible to become a Participant will be notified, prior to each Anniversary Date, of his or her right to become a Participant, to continue participation, or to modify or to cease participation in this Health Care FSA, as applicable, and will be given a reasonable period of time in which to exercise such right. The date on which such annual election period commences and ends will be set forth in the enrollment materials. The election made during an annual election period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless the Participant is eligible to make an election change under Section 3.03A.

An eligible Employee must make an election during each annual election period to participate in the Health Care FSA in the following Plan Year. If the Employee does not submit a signed Salary Reduction Agreement/Election Form for a Plan Year during an annual election period, the Employee may not participate during that Plan Year, except as otherwise permitted under Section 3.03A.

**3.03A Change of Elections.** A Participant may not make any changes to his or her election under the Health Care FSA during the Plan Year except for election changes permitted under Section 3.05 of the Cafeteria Plan, subject to the following: (i) the "Change in Cost" election change under Section 3.05(e) of the Cafeteria Plan does not apply to the Health Care FSA; and (ii) the "Change in Coverage" election change under Section 3.05(f) of the Cafeteria Plan does not apply to the Health Care FSA.

**3.04A Reduction of Certain Elections to Prevent Discrimination.** If the Plan Administrator determines, before or during any Plan Year, that this Health Care FSA may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on contributions allocable to any Participant or class of Participants, the Plan Administrator will take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Participant's or a class of Participants' elections without their consent.

## **ARTICLE IVA CONTRIBUTIONS AND REIMBURSEMENTS**

**4.01A Contributions.** Contributions will be withheld from each Participant's Compensation, and an equivalent amount will be credited to the Participant's Reimbursement Account (although no actual assets will be set aside in that account or any other account). A Participant's contributions for each Plan Year will equal the annual benefit amount elected by the Participant on his or her Salary Reduction Agreement/Election Form for the Plan Year and may not exceed the maximum annual dollar limit for the Health Care FSA set forth in the enrollment materials for the applicable Plan Year.

**4.02A Health Care Reimbursement.** A Participant may receive reimbursement under the Health Care FSA for Eligible Medical Expenses incurred during the Period of Coverage to which the Participant's participation election applies. In addition, certain individuals may receive a reimbursement for Eligible Medical Expenses incurred during the Grace Period immediately following the close of a Plan Year in accordance with Section 4.03A. Each Participant's Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or the Participant, if applicable. The Account will be debited for reimbursements disbursed to the Participant in accordance with this Article IVA. For each Period of Coverage, the entire amount elected by the Participant on the Salary Reduction Agreement/Election Form as an annual amount for the Plan Year for Eligible Medical Expense reimbursement, less any reimbursements already disbursed to the Participant for Eligible Medical Expenses incurred during the Period of Coverage (Grace Period reimbursements from a prior Plan Year are not counted), will be available to the Participant at any time during the Period of Coverage without regard to the amount of contributions made (provided that the periodic contributions have been made). "Incurred" means that the service or treatment giving rise to the expense has been provided.

In no event will the amount of a reimbursement paid to a Participant for any Plan Year exceed the annual amount elected for the Plan Year in the Participant's Salary Reduction Agreement/Election Form for this Health Care FSA. Any amount credited to the Reimbursement Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide a health care reimbursement within the Run Out Period set forth in Section 4.04A. Amounts so forfeited will be used in a manner that is permitted by applicable law.

**4.03A Grace Period.** The Health Care FSA has a "Grace Period" that follows the end of the Plan Year during which amounts that the Participant has allocated to his or her Reimbursement Account that are unused at the end of the Plan Year may be used to reimburse Eligible Medical Expenses incurred during the Grace Period.

The Grace Period will begin on the first day of the next Plan Year and will end two months and 15 days later. To take advantage of the Grace Period, a Participant must be (1) a Participant on the last day of the Plan Year to which the Grace Period relates, or (2) a qualified beneficiary (as defined under COBRA) who is receiving COBRA coverage under the Health Care FSA on the last day of the Plan Year to which the Grace Period relates.

Eligible Medical Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the Grace Period relates, and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.

Expenses incurred during a Grace Period must be submitted before the end of the Run Out Period described in Section 4.04A. Any unused amounts from a Plan Year to which the Grace Period relates that are not used to reimburse Eligible Medical Expenses incurred either during the Plan Year or during the related Grace Period will be forfeited if not submitted for reimbursement before the end of the Run Out Period. A Participant may not use Health Care FSA amounts to reimburse Eligible Dependent Care Expenses, as defined in the Dependent Care FSA.

**4.04A Run Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year or the related Grace Period must be submitted to be eligible for reimbursement. The Run Out Period for a Plan Year ends 90 days after the last day of that Plan Year.

**4.05A Receiving Health Care Reimbursement.** Payment will be made to the Participant in cash as a reimbursement for Eligible Medical Expenses incurred by the Participant (or his or her Spouse or Dependents) while he or she is a Participant during the Plan Year for which the Participant's election is effective, but only if the substantiation requirements of Section 4.06A are satisfied. However, if the Plan Administrator so permits, the Participant may choose to make payment for an Eligible Medical Expense with an electronic payment card arrangement.

**4.06A Substantiation of Expenses.** Each Participant must submit an expense for reimbursement in accordance with the procedures established by the Plan Administrator and must provide the required substantiation as set forth below or as otherwise requested by the Plan Administrator (or its designee). Any reimbursement request submitted on a traditional paper claim form must be accompanied by (1) a statement that the expenses have not

otherwise been reimbursed and that the Participant will not seek reimbursement through any other source, and (2) a written statement from an independent third party (e.g., an itemized statement, Explanation of Benefits, etc.) associated with each expense that contains the following information:

1. the nature of the expense;
2. if the expense is for an over-the-counter drug, the name of the drug;
3. the date(s) of service;
4. the name of the provider;
5. the amount of the expense; and
6. the patient's name.

Use of an electronic payment card may also be made available to Participants to pay for Eligible Medical Expenses under the Health Care FSA. If the Health Care FSA is accessible by an electronic payment card, the Participant will be required to comply with mandatory substantiation procedures, and other mandatory terms and conditions that will govern the Participant's use of the electronic payment card in accordance with Code Section 125 and applicable guidance.

**4.07A Repayment of Excess Reimbursements.** If, as of the end of any Plan Year, it is determined that a Participant has received payments under the Health Care FSA that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.06A or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator will recoup the excess reimbursements in one or more of the following ways:

- a) the Plan Administrator will give the Participant prompt written notice of any excess amount, and the Participant must repay the amount of the excess to the Employer within 60 days of receiving the notification;
- b) the Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- c) the Plan Administrator or the Employer may withhold such amounts from the Participant's Compensation (to the extent permitted under applicable law).

If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth above, the Plan Administrator will notify the Employer that the funds could not be recouped.

**4.08A Reimbursement Following Cessation of Participation.** Participants in the Health Care FSA may submit claims for reimbursement for Eligible Medical Expenses incurred during the Period of Coverage and before the date of participation in the Health Care FSA ceases so long as the claim is submitted prior to the end of the Run Out Period. Unless a COBRA election

is made as set forth in Article VIIA, Participants will not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment or eligibility ceases. Any unused reimbursement benefits at the expiration of the Plan Year will be treated in accordance with Section 4.02A.

**4.09A Coordination of Benefits under the Health Care FSA.** The Health Care FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it will not be considered a group health plan for coordination of benefits purposes, and its benefits will not be taken into account when determining benefits payable under any other plan.

**4.10A Disbursement Reports.** The Plan Administrator will issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Health Care FSA.

**4.11A Timing of Reimbursements.** Reimbursements will be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

**4.12A Non-Alienation of Benefits.** Except as expressly provided by the Employer or the Plan Administrator, no benefit under the Health Care FSA may be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Health Care FSA will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

**4.13A Mental or Physical Incompetency.** Every person receiving or claiming benefits under the Health Care FSA will be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed.

**4.14A Inability to Locate Payee.** If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Health Care FSA because the Plan Administrator cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited after a reasonable time after the date the payment first became due.

**4.15A Tax Effects of Reimbursements.** Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Health Care FSA will be treated as excludable from gross income for federal or state income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant, Spouse, Dependent or other person is includable in an Employee's or other person's gross income for federal or state income tax purposes, then under no circumstances will the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by any person as a result thereof.

**4.16A Forfeiture of Unclaimed Reimbursement Account Benefits.** Any benefit payments under the Health Care FSA that are unclaimed (e.g., uncashed benefit checks) by the last day of the Plan Year after the Plan Year in which the Eligible Medical Expense was incurred will be forfeited.

**ARTICLE VA  
FUNDING AGENT**

The Employer will pay all Health Care FSA reimbursements from its general assets.

**ARTICLE VIA  
CLAIM PROCEDURES**

The Health Care FSA has established procedures for reviewing claims denied under this Health Care FSA. The procedures are set forth in Appendix D.

**ARTICLE VIIA  
CONTINUATION COVERAGE UNDER COBRA**

Notwithstanding any provision to the contrary in this Health Care FSA, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health Care FSA because of a qualifying event as defined under COBRA (and who is a qualified beneficiary as defined under COBRA) will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Care FSA the day before the qualifying event for the periods prescribed by COBRA. Such individuals will be eligible for COBRA continuation coverage only if they had a positive Reimbursement Account balance at the time of the COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event).

If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA coverage for the Health Care FSA will cease at the end of the Plan Year and a Participant cannot continue coverage for the next Plan Year. COBRA continuation coverage will be subject to all the conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary who has COBRA coverage on the last day of the Plan Year may be entitled to reimbursement of Eligible Medical Expenses incurred during the Grace Period following that Plan Year in accordance with Section 4.03A.

If a qualified beneficiary does not elect COBRA continuation coverage, the qualified beneficiary's coverage under the Health Care FSA will end on the date the qualified beneficiary would otherwise lose coverage. The Participant will not be able to receive reimbursements for Eligible Medical Expenses incurred after the date the Participant's employment terminates or the Participant otherwise ceases to be eligible.

**ARTICLE VIIIA  
HIPAA PRIVACY AND SECURITY**

**8.01A Scope and Purpose.** The Health Care FSA will use Protected Health Information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Health Care FSA will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations, etc., as set forth below.

**8.02A Effective Date.** This Article VIIIA is effective on April 14, 2003.

### 8.03A Use and Disclosure of PHI.

- a) **General.** The Health Care FSA will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosures of PHI that will be made by the Health Care FSA.
- b) **Disclosure to the Employer.** The Health Care FSA will disclose PHI to the Employer, or where applicable, an affiliate, only upon receipt of written certification from the Employer that the Employer agrees to implement the provisions in Section 8.04A.

### 8.04A Conditions Imposed on Employer. Notwithstanding any provision of the Health Care FSA to the contrary, the Employer agrees:

- a) not to use or disclose PHI other than as permitted or required by this Article VIIIA or as required by law;
- b) to ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Health Care FSA agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Health Care FSA;
- c) not use or disclose an Individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;
- d) not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;
- e) to report to the Health Care FSA any use or disclosure of PHI that is inconsistent with this Article VIIIA, if it becomes aware of an inconsistent use or disclosure;
- f) to provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;
- g) to make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- h) to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- i) to make internal practices, books and records relating to the use and disclosure of PHI received from the Health Care FSA available to the Secretary of Health and Human Services for purposes of determining the Health Care FSA's compliance with HIPAA;
- j) if feasible, to return or destroy all PHI received from the Health Care FSA that the Employer maintains in any form, and retain no copies of such PHI when no

longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

- k) to ensure adequate separation between the Health Care FSA and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article VIII.A.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information or summary health information, which are not subject to these restrictions) on behalf of the Health Care FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health Care FSA any security incident of which it becomes aware.

**8.05A Designated Employees Who May Receive PHI.** In accordance with the Privacy Rules, only certain employees who perform Health Care FSA administrative functions may be given access to PHI. Those employees who have access to PHI from the Health Care FSA are listed in the Privacy Notice, either by name or individual position.

**8.06A Restrictions on Employees with Access to PHI.** The employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Health Care FSA administration functions that the Employer performs for the Health Care FSA, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, and monitoring.

**8.07A Policies and Procedures.** The Employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

**8.08A Organized Health Care Arrangement.** The Plan Administrator intends the Health Care FSA to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

**8.09A Privacy Official.** The Employer shall designate a Privacy Official, who will be responsible for the Health Care FSA'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 Health Care FSA to the contrary, the Privacy Official shall 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 VIII.A;
- b) transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;
- c) establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Health Care FSA 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 VIII A.

**8.10A Noncompliance.** The Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIII A.

**8.11A Definitions.** As used in this Article VIII A, each of the following capitalized terms shall have the respective meaning given below:

- a. **"Individual"** means the person who is the subject of the health information created, received or maintained by the Health Care FSA or Employer.
- b. **"Organized Health Care Arrangement"** means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.
- c. **"Privacy Notice"** means the notice of the Health Care FSA's privacy practices distributed to Health Care FSA participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.
- d. **"Privacy Rules"** means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.
- e. **"Protected Health Information or PHI"** means individually identifiable health information as defined in 45 C.F.R. § 160.103.

**8.12A Interpretation and Limited Applicability.** This Article VIII A 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 VIII A nor the duties, powers, responsibilities, and obligations listed herein will be taken into account in determining the amount or nature of the benefits provided to any person covered under this Health Care FSA, nor will they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIII A are no longer required by HIPAA, they will be deemed deleted and will have no further force or effect.

**8.13A Services Performed for the Employer.** Notwithstanding any other provision of this Health Care FSA to the contrary, all services performed by a business associate for the Health Care FSA in accordance with the applicable service agreement will be deemed to be performed on behalf of the Health Care FSA and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. Parts 160 through 164, except services that relate to eligibility and enrollment in the Health Care FSA. If a business associate of the Health Care FSA performs any services that relate to eligibility and enrollment in the Health Care FSA, these services will be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Health Care FSA.

**IN WITNESS WHEREOF**, the Employer has executed this Health Care FSA on this \_\_\_\_\_ day of \_\_\_\_\_, 2008.

City of Beverly Hills

By: \_\_\_\_\_

Title: \_\_\_\_\_

# ATTACHMENT 3

## **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT APPENDIX B TO THE CITY OF BEVERLY HILLS CAFETERIA PLAN**

**Amendment and Restatement Effective January 1, 2009**

## TABLE OF CONTENTS

	Page
<b>PREAMBLE</b> .....	<b>1</b>
<b>ARTICLE IB DEFINITIONS</b> .....	<b>2</b>
1.01B "Dependent" .....	2
1.02B "Dependent Care FSA" .....	2
1.03B "Eligible Dependent Care Expense(s)" .....	2
1.04B "Participant" .....	2
1.05B "Qualifying Dependent Care Services" .....	2
1.06B "Qualifying Individual" .....	2
1.07B "Reimbursement Account" .....	3
1.08B "Spouse" .....	3
<b>ARTICLE IIB ELIGIBILITY AND PARTICIPATION</b> .....	<b>3</b>
2.01B Eligibility to Participate .....	3
2.02B Termination of Participation .....	3
2.03B Participation Following Termination of Employment or Loss of Eligibility .....	4
<b>ARTICLE IIIB ELECTION TO PARTICIPATE</b> .....	<b>4</b>
3.01B Initial Election Period .....	4
3.02B Annual Election Period .....	4
3.03B Change of Elections .....	4
3.04B Reduction of Certain Elections to Prevent Discrimination .....	5
<b>ARTICLE IVB CONTRIBUTIONS AND REIMBURSEMENTS</b> .....	<b>5</b>
4.01B Maximum Contributions .....	5
4.02B Dependent Care Reimbursement .....	6
4.03B Grace Period .....	6
4.04B Run Out Period .....	7
4.05B Receiving Dependent Care Reimbursement .....	7
4.06B Substantiation of Expenses .....	7
4.07B Repayment of Excess Reimbursements .....	8
4.08B Reimbursement Following Cessation of Participation .....	8
4.09B Disbursement Reports .....	8
4.10B Timing of Reimbursements .....	8
4.11B Non-Alienation of Benefits .....	8
4.12B Mental or Physical Incompetency .....	8
4.13B Inability to Locate Payee .....	9
4.14B Tax Effects of Reimbursements .....	9
4.15B Forfeiture of Unclaimed Reimbursement Account Benefits .....	9
<b>ARTICLE VB FUNDING AGENT</b> .....	<b>9</b>
<b>ARTICLE VIB CLAIM PROCEDURES</b> .....	<b>9</b>

## **PREAMBLE**

The City of Beverly Hills established this Dependent Care Flexible Spending Account (the "Dependent Care FSA") effective January 1, 2003, for the benefit of employees who are covered by City of Beverly Hills Cafeteria Plan ("Plan" or "Cafeteria Plan"), and who choose to contribute to a Dependent Care FSA Reimbursement Account established under this Dependent Care FSA. It is hereby amended and restated in its entirety, effective January 1, 2009.

This Dependent Care FSA is intended to provide reimbursement of certain eligible dependent care expenses incurred by the Participant. The Employer intends that the Dependent Care FSA qualify as a dependent care assistance program under Section 129 of the Internal Revenue Code, as amended ("Code"), and that the benefits provided under the Dependent Care FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code. This Dependent Care FSA is a component of, and incorporated by reference into, the Cafeteria Plan, and Articles VI, VII, VIII and IX of the Cafeteria Plan document apply also to this Dependent Care FSA.

## ARTICLE IB DEFINITIONS

Unless otherwise specified, capitalized terms in this Appendix B have the same meaning as the defined terms in the Cafeteria Plan. The definitions of terms defined in this Appendix B, but not defined in the Cafeteria Plan, are only applicable with respect to this Appendix B. If a term is defined both in the Cafeteria Plan and in this Appendix B, the definition in this Appendix B applies.

**1.01B "Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a). A Dependent also means a person defined in Code Section 21(e)(5) (i.e., a dependent of the parent with custody for the greatest portion of the year).

**1.02B "Dependent Care FSA"** means this Dependent Care Flexible Spending Account, as amended from time to time.

**1.03B "Eligible Dependent Care Expense(s)"** means an expense that is an employment-related expense under Code Section 21(b)(2) that is incurred for the care of a Qualifying Individual and that is necessary for gainful employment of the Participant and Spouse, if any, and expenses for incidental household services, if paid for by the Participant to obtain Qualifying Dependent Care Services. An Eligible Dependent Care Expense does not include a payment made to (1) an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or his or her Spouse; (2) a Participant's Spouse; (3) a Participant's child (as defined in Code Section 152(f)(1) who is under age 19 at the end of the Plan Year in which the expense was incurred); or (4) a parent of a Participant's under-age-13 qualifying child. Eligible Dependent Care Expenses are eligible for reimbursement under this Dependent Care FSA.

**1.04B "Participant"** means a person who has met the eligibility requirements under Section 2.01B, elected to participate in accordance with that section, and whose participation has not terminated under Section 2.02B.

**1.05B "Qualifying Dependent Care Services"** means services that are both (1) related to the care of a Qualifying Individual that enables the Participant and Spouse to remain gainfully employed, and (2) performed:

- in the Participant's home, or
- outside the Participant's home for (i) the care of a Participant's qualifying child who is under age 13, or (ii) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's home.

If the services are provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

**1.06B "Qualifying Individual"** means (1) a tax dependent of the Participant as defined in Code Section 152 who is under age 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1); (2) a tax dependent of the Participant as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is

physically and mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half the year; or (3) a Participant's Spouse who is physically and mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child will, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and will not be treated as a Qualifying Individual with respect to the non-custodial parent.

**1.07B "Reimbursement Account"** is the bookkeeping entry to record amounts withheld from a Participant's Compensation and that are available for a future reimbursement of a Participant's Eligible Dependent Care Expense. No money will actually be allocated to or held under any individual Participant's account. A Reimbursement Account will be maintained by the Plan Administrator for accounting purposes, and will not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant's Reimbursement Account.

**1.08B "Spouse"** means an individual who is legally married to a Participant, and who is treated as a spouse under the Code, excluding any individual (1) who is legally separated from the Participant under a divorce or separate maintenance decree; or (2) who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

## **ARTICLE IIB ELIGIBILITY AND PARTICIPATION**

**2.01B Eligibility to Participate.** Each Employee is eligible to participate in the Dependent Care FSA on the date he or she becomes an Employee. The Employee's commencement of participation in the Dependent Care FSA is conditioned on the Employee properly completing a Salary Reduction Agreement/Election Form and submitting it to the Plan Administrator during the applicable election period under Section 3.01B or 3.02B.

**2.02B Termination of Participation.** A Participant's participation in the Dependent Care FSA will terminate on the earliest of the following dates:

- a. the date the Participant makes a permitted election not to participate in the Dependent Care FSA;
- b. the last day of the Plan Year unless the Participant elects to continue to participate in the next Plan Year;
- c. the date that the Participant no longer satisfies the eligibility requirements of the Dependent Care FSA;
- d. the date the Participant's employment with the Employer terminates; or
- e. the date that the Dependent Care FSA is either terminated or amended to exclude the Participant or the class of employees to which the Participant belongs.

Termination of employment or cessation of eligibility will automatically revoke any Salary Reduction Agreement/Election Form. If revocation occurs under this Section 2.02B, no new election with respect to the Dependent Care FSA may be made during the remainder of the Plan Year except as set forth in Section 2.03B.

### **2.03B Participation Following Termination of Employment or Loss of Eligibility.**

If a former Participant is rehired as an eligible Employee or becomes eligible again more than 30 days after the Participant's termination of employment or loss of eligibility, he or she may make new elections under the Dependent Care FSA. If a Participant's employment with the Employer terminates and the Participant is rehired as an eligible Employee within 30 days or less after the termination date, or if a Participant again becomes eligible within 30 days or less after a loss of eligibility, the same elections that were in effect at the time the individual terminated employment or lost eligibility will be reinstated and will remain in effect for the remainder of the Plan Year (unless the Participant changes his or her election as permitted under Section 3.03B).

## **ARTICLE IIIB ELECTION TO PARTICIPATE**

**3.01B Initial Election Period.** To become a Participant, an Employee who first becomes eligible to participate in this Dependent Care FSA mid-year must complete, sign and file a Salary Reduction Agreement/Election Form with the Plan Administrator (or its designated third-party administrator as set forth on the Salary Reduction Agreement/Election Form) during the initial election period set forth in the enrollment materials. Participation will commence under this Dependent Care FSA on the date the Participant files a properly completed Salary Reduction Agreement/Election Form with the Plan Administrator (or its designated third-party administrator) or on such later date specified by the Plan Administrator. An eligible Employee who does not submit a signed Salary Reduction Agreement/Election Form in accordance with this Section 3.01B during an initial election period may become a Participant on a later date in accordance with Section 3.02B or 3.03B.

**3.02B Annual Election Period.** Each Employee who is a Participant or who is eligible to become a Participant will be notified, prior to each Anniversary Date, of his or her right to become a Participant, to continue participation, or to modify or to cease participation in this Dependent Care FSA, as applicable, and will be given a reasonable period of time in which to exercise such right. The date on which such annual election period commences and ends will be set forth in the enrollment materials. The election made during an annual election period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless the Participant is eligible to make an election change under Section 3.03B.

An eligible Employee must make an election during each annual election period to participate in the Dependent Care FSA in the following Plan Year. If the Employee does not submit a signed Salary Reduction Agreement/Election Form for a Plan Year during an annual election period, the Employee may not participate during that Plan Year, except as otherwise permitted under Section 3.03B.

**3.03B Change of Elections.** A Participant may not make any changes to his or her election under the Dependent Care FSA during the Plan Year except for election changes permitted under Section 3.05 of the Cafeteria Plan, subject to the following:

- a. a "Change in Status" election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion;
- b. the "Change in Cost" election change applies only if the cost change is imposed by a dependent care provider who is not a "relative" of the Participant (for this purpose, a relative is an individual who is related as described in Code Section 152(d)(2)(A) through (G), incorporating the rules of Code Sections 125(f)(1) and 152(f)(4)); and
- c. the "Change in Coverage" election change applies only if the election change is on account of and corresponds with a change in a dependent care service provider.

**3.04B Reduction of Certain Elections to Prevent Discrimination.** If the Plan Administrator determines, before or during any Plan Year, that this Dependent Care FSA may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on contributions allocable to any Participant or class of Participants, the Plan Administrator will take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Participant's or a class of Participants' elections without their consent.

#### **ARTICLE IVB CONTRIBUTIONS AND REIMBURSEMENTS**

**4.01B Maximum Contributions.** Contributions will be withheld from each Participant's Compensation, and an equivalent amount will be credited to the Participant's Reimbursement Account (although no actual assets will be set aside in that account or any other account). A Participant's contributions for each Plan Year will equal the annual benefit amount elected by the Participant on his or her Salary Reduction Agreement/Election Form for the Plan Year and may not exceed the following maximum annual benefit limits.

The maximum annual benefit amount that a Participant may elect for reimbursements of Eligible Dependent Care Expenses incurred in any Period of Coverage is \$5,000 in accordance with Code section 129 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- a. The Participant's earned income (as defined in Code Section 32) for the Plan Year;
- b. The Participant's Spouse's earned income (as defined in Code Section 32) for the Plan Year (note: a Spouse who is not employed during a month in which the Participant incurs an Eligible Dependent Care Expense, and is either physically or mentally incapable of self-care or a Student will be deemed to have earned income in the amount of \$250 per month per Qualifying Individual for whom the

Participant incurs Eligible Dependent Care Expenses, up to a maximum amount of \$500 per month);

- c. Either \$5,000 or \$2,500 per Plan Year as applicable:
- i. \$5,000 for the Plan Year if one of the following applies:
    - the Participant is married and files a joint federal income tax return;
    - the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half the taxable year) the principal abode of a Qualifying Individual; (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or
    - the Participant is single or is a head of the household for federal income tax purposes; or
  - ii. \$2,500 for the Plan Year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

**4.02B Dependent Care Reimbursement.** A Participant may receive reimbursement under the Dependent Care FSA for Eligible Dependent Care Expenses incurred during the Period of Coverage to which the Participant's participation election applies. In addition, certain individuals may receive a reimbursement for Eligible Dependent Care expenses incurred during the Grace Period immediately following the close of a Plan Year in accordance with Section 4.03B. Each Participant's Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or the Participant, if applicable. The Account will be debited for reimbursements disbursed to the Participant in accordance with this Article IVB. The amount available to a Participant for reimbursement of an Eligible Dependent Care Expense may not exceed the year-to-date amount credited to the Participant's Dependent Care FSA Reimbursement Account, less any prior reimbursements (Grace Period reimbursements from a prior Plan Year are not counted). A Participant's Dependent Care FSA Reimbursement Account may not have a negative balance during the Plan Year. "Incurred" means that the Qualifying Dependent Care Services giving rise to the expense has been furnished.

In no event will the amount of reimbursements paid to a Participant for any Plan Year exceed the annual amount elected for the Plan Year in the Participant's Salary Reduction Agreement/Election Form for this Dependent Care FSA. Any amount credited to the Reimbursement Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide a Dependent Care reimbursement within the Run Out Period set forth in Section 4.04B. Amounts so forfeited will be used in a manner that is permitted by applicable law.

**4.03B Grace Period.** The Dependent Care FSA has a "Grace Period" that follows the end of the Plan Year during which amounts that the Participant has allocated to his or her Reimbursement Account that are unused at the end of the Plan Year may be used to reimburse Eligible Dependent Care Expenses incurred during the Grace Period.

The Grace Period will begin on the first day of the next Plan Year and will end two months and 15 days later. To take advantage of the Grace Period, a Participant must be a Participant on the last day of the Plan Year to which the Grace Period relates.

Eligible Dependent Care Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the Grace Period relates, and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.

Expenses incurred during a Grace Period must be submitted before the end of the Run Out Period described in Section 4.04B. Any unused amounts from the end of a Plan Year to which the Grace Period relates that are not used to reimburse Eligible Dependent Care Expenses incurred either during the Plan Year or during the related Grace Period will be forfeited if not submitted for reimbursement before the end of the Run Out Period. A Participant may not use Dependent Care FSA amounts to reimburse Eligible Medical Expenses, as defined in the Health Care FSA.

**4.04B Run Out Period.** The Run Out Period is the period during which expenses incurred during a Plan Year or the related Grace Period must be submitted to be eligible for reimbursement. The Run Out Period for a Plan Year ends 90 days after the last day of that Plan Year.

**4.05B Receiving Dependent Care Reimbursement.** Payment will be made to the Participant in cash as a reimbursement for Eligible Dependent Care Expenses incurred by the Participant or his or her Spouse or Dependents while he or she is a Participant during the Plan Year for which the Participant's election is effective, but only if the substantiation requirements of Section 4.06B are satisfied.

**4.06B Substantiation of Expenses.** Each Participant must submit an expense for reimbursement in accordance with the procedures established by the Plan Administrator and must provide the required substantiation as set forth below or as otherwise requested by the Plan Administrator (or its designee). Any reimbursement request must be accompanied by (1) a statement that the expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source and (2) the following information:

- a. the name of the person on whose behalf Eligible Dependent Care Expenses have been incurred;
- b. the nature and date of the expense so incurred;
- c. the amount of the expense; and
- d. the name of the person, organization or entity to whom the expense was or is to be paid, and their taxpayer identification number.

The Participant's reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party showing that the Eligible Dependent Care Expenses have been incurred and the amount of such expenses.

**4.07B Repayment of Excess Reimbursements.** If, as of the end of any Plan Year, it is determined that a Participant has received payments under the Dependent Care FSA that exceed the amount of Eligible Dependent Care Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.06B or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator or Employer will recoup the excess reimbursements in one or more of the following ways:

- a) the Plan Administrator will give the Participant prompt written notice of any excess amount, and the Participant must repay the amount of the excess to the Employer within 60 days of receiving the notification;
- b) the Plan Administrator may offset the excess reimbursement against any other Eligible Dependent Care Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- c) the Plan Administrator or the Employer may withhold such amounts from the Participant's Compensation (to the extent permitted under applicable law).

If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth above, the Plan Administrator will notify the Employer that the funds could not be recouped.

**4.08B Reimbursement Following Cessation of Participation.** Participants in the Dependent Care FSA may submit claims for reimbursement for Eligible Dependent Care Expenses incurred during the Period of Coverage and before the date of participation in the Dependent Care FSA ceases so long as the claim is submitted prior to the end of the Run Out Period. Participants will not be entitled to receive reimbursement for Eligible Dependent Care Expenses incurred after employment or eligibility ceases. Any unused reimbursement benefits at the expiration of the Plan Year will be treated in accordance with Section 4.02B.

**4.09B Disbursement Reports.** The Plan Administrator will issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Dependent Care FSA.

**4.10B Timing of Reimbursements.** Reimbursements will be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

**4.11B Non-Alienation of Benefits.** Except as expressly provided by the Employer or the Plan Administrator, no benefit under the Dependent Care FSA may be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Dependent Care FSA will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

**4.12B Mental or Physical Incompetency.** Every person receiving or claiming benefits under the Dependent Care FSA will be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed.

**4.13B Inability to Locate Payee.** If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Dependent Care FSA because the Plan Administrator cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited after a reasonable time after the date the payment first became due.

**4.14B Tax Effects of Reimbursements.** Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Dependent Care FSA will be treated as excludable from gross income for federal or state income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant, Spouse, Dependent or other person is includable in an Employee's or other person's gross income for federal or state income tax purposes, then under no circumstances will the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by any person as a result thereof.

**4.15B Forfeiture of Unclaimed Reimbursement Account Benefits.** Any benefit payments under the Dependent Care FSA that are unclaimed (e.g., uncashed benefit checks) by the last day of the Plan Year after the Plan Year in which the Eligible Dependent Care Expense was incurred will be forfeited.

**ARTICLE VB  
FUNDING AGENT**

The Employer will pay all Dependent Care FSA reimbursements from its general assets.

**ARTICLE VIB  
CLAIM PROCEDURES**

The Dependent Care FSA has established procedures for reviewing claims denied under this Dependent Care FSA. The procedures are set forth in Appendix D.

**IN WITNESS WHEREOF**, the Employer has executed this Dependent Care FSA on this \_\_\_\_\_ day of \_\_\_\_\_, 2008.

City of Beverly Hills

By: \_\_\_\_\_

Title: \_\_\_\_\_

# ATTACHMENT 4

## **BENEFIT PLAN OPTIONS APPENDIX C TO THE CITY OF BEVERLY HILLS CAFETERIA PLAN**

**BENEFIT PLAN OPTIONS  
CITY OF BEVERLY HILLS CAFETERIA PLAN**

**A. Cafeteria Plan**

1. Health Insurance

- Kaiser Permanente California
- Blue Shield Access + HMO
- Blue Shield NetValue HMO
- PERSCare
- PERS Choice
- PERS Select
- Peace Officers Research Association of California (PORAC) Police & Fire Health Plan (Police and Fire Employees ONLY)

2. Dental Insurance

- [Guardian DentalGuard Preferred Network]

3. Vision Insurance

- Vision Service Plan (VSP)

4. Life Insurance

- [Guardian Life Insurance Company]

**B. Health Care Flexible Spending Account**

**C. Dependent Care Flexible Spending Account**

**BENEFIT PLAN OPTIONS  
APPENDIX C TO THE CITY OF BEVERLY HILLS CAFETERIA PLAN**

**BENEFIT PLAN OPTIONS  
CITY OF BEVERLY HILLS CAFETERIA PLAN**

**A. Cafeteria Plan**

1. Health Insurance

- Kaiser Permanente California
- Blue Shield Access + HMO
- Blue Shield NetValue HMO
- PERSCare
- PERS Choice
- PERS Select
- Peace Officers Research Association of California (PORAC) Police & Fire Health Plan (Police and Fire Employees ONLY)

2. Dental Insurance

- [Guardian DentalGuard Preferred Network]

3. Vision Insurance

- Vision Service Plan (VSP)

4. Life Insurance

- [Guardian Life Insurance Company]

**B. Health Care Flexible Spending Account**

**C. Dependent Care Flexible Spending Account**

# ATTACHMENT 5

**CLAIM PROCEDURES  
APPENDIX D TO THE CITY OF BEVERLY HILLS CAFETERIA PLAN**

**CLAIM PROCEDURES  
CITY OF BEVERLY HILLS CAFETERIA PLAN**

Capitalized terms in this Appendix D have the same meaning as the defined terms in the City of Beverly Hills Cafeteria Plan (the "Plan").

The Plan Administrator will receive all claims filed for benefits under the Plan. Upon receipt, the Plan Administrator shall review the claim and determine whether the claimant is entitled to receive any benefits under the claim. The Plan Administrator shall notify the claimant in writing of any adverse decision with respect to his or her claim within 120 days after its submission.

If the circumstances require an extension of time for processing the initial claim, a written notice of the extension will be furnished to the claimant before the end of the initial 120-day period. The extension will not exceed a period of 120 days from the last day of the initial 120-day period. The extension notice must indicate the circumstances requiring an extension of time.

If a claim for benefits is denied or if the Plan Administrator has not responded to the claim within the time period set out in the preceding paragraph (in which case the claim for benefits will be deemed to be denied on the last day of the applicable time period), the claimant or his or her duly authorized representative, at the claimant's sole expense, may appeal the denial by submitting written notice of appeal to the Plan Administrator (or a person or entity appointed by the Plan Administrator) within 90 days of the receipt of written notice of the denial or 60 days from the date the claim is deemed to be denied.

The claimant will be notified of the decision on the appeal within 90 days of receipt of the notice of appeal, unless circumstances require an extension of time for processing, in which case a decision will be rendered as soon as possible, but not later than 120 days after receipt of a notice of appeal. If such an extension of time is required, written notice of the extension will be furnished to the claimant before the end of the original 90-day period. The notice of decision on the appeal must be made in writing. If the decision on the appeal is not furnished within the time specified above, the appeal of the claim will be deemed denied.