COUNTY OF SAN BERNARDINO

MEDICAL EXPENSE REIMBURSEMENT PLAN

Established July 27, 2002
Amended November 18, 2003
Amended July 19, 2005
Amended March 25, 2008
Amended July 17, 2010

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MEDICAL EXPENSE REIMBURSEMENT PLAN

ARTICLE I - INTRODUCTION

1.1 Establishment of Plan

San Bernardino County (the County) established the Medical Expense Reimbursement Plan (the Plan) effective July 27, 2002.

This amendment supersedes and replaces any prior statements of Medical Expense Reimbursement Plan coverage for this Plan and is effective on July 17, 2010.

The purpose of this Plan is to permit Participants to pay for Qualifying Medical Care Expenses on a pre-tax basis.

1.2 Purpose of Amendment

The purpose of this Amendment includes but is not limited to:

1. Removes “legal separation” from the list of qualifying events to make changes to elections under this Plan.
2. Extends the election period for allowable changes to elections under this plan from 31 to 60 days.
3. Defines the terms “County” and “Open Enrollment.”
4. Expands the Open Enrollment period to allow changes made after the conclusion of Open Enrollment but before the beginning of the next Plan Year.
5. Incorporates the provisions of the HEART Act to allow Qualified Reservist Distributions for reservists called into active duty for more than 180 days.
6. Reduces the time period for reinstatement of former participant at benefit level prior to termination to 30 days from 31 to comply with IRC.
7. Reduces the required number of hours for FSA participation from 41 to 40 to match Memoranda of Understanding.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended (the Code) and the regulations issued there under, including the special regulatory requirements pertaining to health flexible spending arrangements. This Plan is also intended to qualify as a "self-insured medical reimbursement plan" under Section 105(h) of the Code. Further, the reimbursements of Qualifying Medical Care Expenses under this Plan are intended to be eligible for exclusion from Participant’s gross income under Section 105(b) of the Code.

ARTICLE II - DEFINITIONS AND CONSTRUCTION

2.1 Definitions

(a) **Change in Status Event** means the events described below and any other events that the Plan Administrator, in its sole discretion, determines to be within prevailing IRS guidance.

(1) A change in a Participant’s legal marital status, including marriage, death of a Spouse, divorce, or annulment.

(2) A change in the Participant’s number of Dependents, including the birth, adoption or placement for adoption of an adopted or foster child, or the death of a Dependent.

(3) Termination or commencement of employment by the Participant, the Participant’s Spouse, or the Participant’s Dependent.

(4) A reduction or increase in hours of employment by the Participant, the Participant's Spouse, or the Participant's Dependent, including a switch between part-time and full-time status, a strike or lockout, or commencement or return from an unpaid leave of absence.

(5) A Dependent satisfying or ceasing to satisfy the Dependent eligibility requirements for a particular benefit, i.e. attaining a specified age, marital status, or student status.

(b) **County** means the County of San Bernardino, including any districts that are governed by the Board of Supervisors and any entity with an agreement in place with the County to receive the benefits of this plan.

(c) **Compensation** means the total Form W-2 compensation for federal income tax withholding purposes paid by the Employer to an Employee for services performed, determined prior to any Salary Reduction election under this Plan, any Salary Reduction election under any other Code Section 125 cafeteria plan, and any elective salary deferral contributions under any Code Section 401(k), 414(h), and 457 arrangements.

(d) **Dependent** means an individual who meets the definition of a qualifying child or a qualifying relative of the participant (as defined in IRC Section 152, determined without regard to § 152(b) (1), (b) (2), and (d) (1) (B)):

(1) The qualifying child must be the employee's son, daughter, stepchild, sibling or stepsibling, or a descendant of any such individual. Also eligible are a foster child, legally adopted child or a child lawfully placed with the employee for adoption, or a child for whom the Participant has court-appointed guardianship and a legal and financial support obligation.

The child must be under age 19, or under age 24 if a full time student. There is no age limit in the case of a child who is totally and permanently mentally or physically disabled.

The child must have the same principal place of abode as the employee for more than 1/2 of the taxable year. Temporary absences due to illness, education, vacation, or military service are permissible.

The child must not provide more than 1/2 of his or her own support for the taxable year.

(2) The qualifying relative may either meet the relationship requirements of a qualifying child **or** may be any individual who has the same principal place of abode as the employee and is a member of the employee's household for the entire taxable year.

The individual must not meet the eligibility requirements of a qualifying child of the employee or any other person.

In all cases, the child or relative must be claimed as a dependent of the Participant on his/her federal income tax return for the Plan Year. Notwithstanding the foregoing, this Plan will provide benefits in accordance with the applicable requirements of any valid court order.

Effective July 30, 2011, "Dependent" shall include any child of an employee up to the 26th birthday, without respect to marital, student, or disability status, and who is not eligible for other group health plan coverage.

In the event that federal law or regulation permits broader coverage for dependents than is allowed at the time of adoption of this amendment such that dependents currently covered but might lose coverage, it is the intent of the County to hereby incorporate such broader dependent coverage.

(e) **Effective Date** of this Plan means the date this plan was originally established by the County on July 27, 2002. For purposes of this Amendment, it means the date the amended and restated plan is placed into effect by the Board of Supervisors, July 17, 2010.

(f) **Election Period** means the period of time that an Employee has to enroll for participation in the Plan or to change an election. For purposes of Open Enrollment, it means the time period designated by the Plan Administrator during which changes can be made for the next Plan Year, including changes that are made after the conclusion of the designated Open Enrollment Period, but before the beginning of the next Plan Year. For purposes of an Employee who becomes eligible to participate mid-Plan Year (for example, a new hire), it means sixty (60) days from the date that the Employee became eligible (for example, the effective date of the new Employee's employment). For purposes of a Change in Status Event, it means sixty (60) days from the date of the Change in Status Event. Elections shall only apply to Compensation that has not yet been earned at the time of the election unless otherwise allowed under the terms of this Plan.

(g) **Employee** means an individual who is employed by the County, or any entity with an agreement in place with the County to receive the benefits of this Plan, in a regular position who is regularly scheduled to work 40 or more hours per Pay Period and is eligible to receive the benefits of the Medical Expense Reimbursement Plan as provided in Article III, Participation, Section 3.1, Eligibility to Participate. The term Employee does not include any employee who is eligible to participate in the Exempt Medical Reimbursement Plan, any leased employee [including, but not limited to those individuals defined in Code Section 414(n)], or an individual classified by the Employer as an independent contractor, temporary or casual Employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer, but who is paid by a temporary or other employment agency, such as "Kelly," "Manpower," etc.

(i) **Employer** means the County of San Bernardino (the County), any Special District governed by the Board of Supervisors of the County of San Bernardino, and any entity with an agreement in place with the County to receive the benefits of this Plan.

(j) **Group Health Plan** means the plan or plans the Employer maintains for its Employees (and their Spouses and Dependents), providing medical, dental or vision benefits through self-insurance, an insurance policy or policies (including HMOs), and which qualify as accident or health plans under Code Section 106.

(k) **Medical Expense Reimbursement Plan Account** or **Account** means the Account established with respect to each Participant as described in Section 6.5 of this Plan.

(l) **Medical Expense Reimbursement (FSA) Enrollment Form** means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to elect to participate in the Plan by authorizing Salary Reductions and electing to receive reimbursements for Qualifying Medical Care Expenses, or to change an existing election if permitted under the Plan. At the option of the Employer, this form may be created as part of a telephonic or electronic enrollment system.

(m) **Memorandum of Understanding means the current** Memorandum of Understanding between the County of San Bernardino and the San Bernardino Public Employees Association concerning the Employees in the Administrative Services; Clerical; Craft, Labor and Trades; Management; Professional; Supervisory; and Technical and Inspection units and the current Memorandum of Understanding between the County of San Bernardino and the San Bernardino County Public Attorneys' Association concerning the Employees in the Public Attorneys unit and the current Memorandum of Understanding between the County of San Bernardino and the San Bernardino County Safety Employees Benefit Association concerning the employees in the Specialized Peace Officer and Specialized Peace Officer Supervisory and Safety Management and Supervisory units or any other Memorandum of Understanding with an exclusive recognized employee organization approved by the Board of Supervisors.

(n) **Open Enrollment Period** means the time period designated by the Plan Administrator during which changes can be made for the next Plan Year.

(o) **Participant** means an Employee who is participating in this Plan in accordance with the provisions of Article III, Participation.

(p) **Plan** means the Medical Expense Reimbursement Plan as set forth herein and as amended from time to time.

(q) **Plan Administrator** means the Human Resources' Benefits Chief, Employee Benefits and Services Division, who is vested with the authority to administer this Plan.

(r) **Plan Year** means the 12-month period that coincides with the County's Benefit Plan Year commencing on the first day of Pay Period 17 in one calendar year and ending on the last day of Pay Period 16 in the succeeding calendar year for the purposes of both Salary Reduction and Claims Reimbursement.

(s) **Qualifying Medical Care Expense** means an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213 of the Code (including, without limitation, amounts paid for hospital bills, doctor and dental bills, and prescription drugs), but only to the extent that the Participant or other person incurring the expense is neither reimbursed for nor entitled to reimbursement for the expense through the Group Health Plan, other insurance or other accident or health plan.

A medical expense is incurred at the time the medical care or service which gave rise to the expense is furnished, and not when the Participant is formally billed.

A Qualifying Medical Care Expense shall not include an expense incurred for cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Furthermore, a Qualifying Medical Care Expense shall not include insurance premiums paid for health care coverage. This paragraph is not a complete list of exclusions under IRC Section 213.

(t) **Salary Reduction** means the amount by which a Participant's Compensation is reduced to pay the premiums for the benefit provided under this plan.

(u) **Spouse** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code).

2.2 Gender and Number

Except when plainly indicated by the context, any masculine terminology used herein shall also include the feminine, and any term used in the singular herein shall also include the plural.

2.3 Headings

The headings of the various articles, sections, and subsections are inserted for the convenience of reference only and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision of this Plan.

2.4 Plan Provisions Controlling

In the event the terms or provisions of any summary description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth herein, the provisions of this Plan shall be controlling.

2.5 Severability

In the event any provision of this Plan shall be held illegal or invalid for any reason, this illegality or invalidity shall not affect the remaining provisions of this Plan, and such remaining provisions shall be fully severable and this Plan shall, to the extent practicable, be construed and enforced as if the illegal or invalid provision had never been inserted herein.

2.6 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall 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 shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

ARTICLE III - PARTICIPATION

3.1 Eligibility to Participate

An Employee is eligible to participate in this Plan if he is eligible to receive the benefits of the Plan provided for in a Memorandum of Understanding, and is not eligible for benefits through the Exempt Medical Reimbursement Plan.

3.2 Election to Participate; Commencement of Participation

(a) *Elections during Open Enrollment Period.* During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide a Medical Expense Reimbursement (FSA) Enrollment Form via eBenefits to each Eligible Employee. The Medical Expense Reimbursement (FSA) Enrollment Form shall enable the Employee to elect to participate in the Plan for the Plan Year, to elect an annual benefit amount, and to authorize the necessary Salary Reductions to pay for the premium for his benefits under the Plan. The Medical Expense Reimbursement (FSA) Enrollment Form shall be due and returnable to the Plan Administrator during the Open Enrollment Period, or after the conclusion of the designated Open Enrollment Period, but before the beginning of the subsequent Plan Year. However, if the last day of the Open Enrollment Period or the last day before the beginning of the subsequent Plan Year falls on a holiday or weekend, the enrollment period shall be extended to the next working day. If an Eligible Employee elects to participate during an Open Enrollment Period, he becomes a Participant on the first day of the applicable Plan Year. If an Eligible Employee fails to elect enrollment in the Plan during the Open Enrollment Period, or after the open Enrollment Period but before the beginning of the subsequent Plan Year he may not elect to participate in this Plan until the next Open Enrollment Period.

(b) *Elections by Employees who are Hired or First Become Eligible to Participate after the Beginning of the Plan Year.* An Employee who is hired by the Employer after the beginning of the Plan Year, or who first becomes eligible to participate by satisfying the eligibility requirements of Section 3.1 above after the beginning of the Plan Year, must elect to enroll in the Plan within 60 days of becoming eligible to participate in the Plan. However, if the last day of the 60 days falls on a holiday or weekend, the enrollment period shall be extended to the next working day. Otherwise, the Employee must wait until the Plan's next Open Enrollment Period to elect to participate in the Plan.

(c) *Eligible Employee Who Fails to File an Enrollment Form.* If an Eligible Employee fails to file (or fails to timely file) a Medical Expense Reimbursement (FSA) Enrollment Form with respect to a Plan Year, he will not be considered a Participant in the Plan for the duration of the Plan Year, and he may not elect to participate in the Plan until the next Open Enrollment Period.

3.3 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earliest of:

(a) The end of the Plan Year for which he has elected to participate (unless during the Open

Enrollment Period for the next Plan Year he elects to continue participating);

(b) The date on which the Plan terminates;

(c) The date on which he ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee under Section 3.1;

(d) The date on which a Participant's election otherwise expires or is terminated; or

(e) The date on which a Participant fails to pay any required contribution, including payment by Salary Reduction.

Termination of an Employee's participation in this Plan shall cause the Participant's elections made under this Plan to be automatically revoked. Reimbursements after termination of participation will be made pursuant to Article VI, Reimbursement Procedure, Section 6.4, Termination of Benefits.

3.4 Participation Following Termination of Employment

Except as otherwise provided herein, former Participants who are rehired in a position eligible to participate in the Plan within thirty (30) days of the date of the termination of their employment will be reinstated with the same election(s) such individuals had before termination. If a former Participant is rehired in a position eligible to participate in the Plan more than thirty-one (31) days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election.

3.5 Heroes Earning Assistance and Relief Tax Act of 2008 (HEART Act)

If a Military Reservist is called for at least 180 days of active duty, he is enabled by the HEART Act to a Qualified Reservist Distribution (QRD) by which he may withdraw any unused funds remaining in a Medical Expense Reimbursement (FSA) Account at the time of call. This disbursement, if elected, will be paid as a taxable cash distribution before the end of the applicable Plan Year. Documentation of the call to active duty must be submitted along with the Medical Expense Reimbursement Claim Form.

3.6 Family and Medical Leave Act of 1993 (FMLA)

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying paid or unpaid leave under the Family and Medical Leave Act (FMLA) of 1993, to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Expense Reimbursement Plan benefits on the same terms and conditions as though he were still an active Employee, to the extent the Employee opts to continue his coverage. If the Employee opts to continue his coverage, the Employee may pay his contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of his pre-leave Compensation by making a special election to that effect prior to the date such Compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next Plan Year), or the Employee may pay his contribution upon return from leave by pre-tax Salary Reduction within the time frame the contributions were not paid during the leave (provided, however, that the pre-tax dollars may not be utilized to fund coverage during the previous Plan Year), or via other arrangements agreed upon between the Employee and the Plan Administrator. If the Employee chooses not to make contributions to the Plan for the period of such leave, the annual benefit amount shall be adjusted and, during the leave where no contributions are made, any expenses incurred will not be eligible for reimbursement. Upon return from such leave, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

3.7 Uniformed Service under USERRA

If an Employee is absent from employment with the County on account of being in "uniformed service" as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), he may elect to continue participation in the Plan. The coverage period will extend through the end of the current plan year or until he fails to apply for reinstatement or to return to employment with his Employer. The Employee will be responsible for making the required contributions under the Plan during the period he is in "uniformed service." If he elects to continue participation in the Plan during leave under USERRA, the following are payment options:

(a) Pre-Payment Option: Payment of contributions arranged in advance of the leave with either after-tax or pre-tax Compensation (through salary, vacation pay or sick pay to the extent permitted by law) by sending payment to the Employee Benefits and Services Division.

(b) Pay-as-You-Go Option: Payment made on the same basis as payments would have been made had the Employee not been on leave, on the same schedule as COBRA payments, under any of the Employer's existing rules for payment by Employees not on leave without pay, or by any other method that is mutually acceptable by the Plan Administrator and the Employee as allowed by the Code.

(c) Catch-up Option: Payment made upon return from leave by pre-tax Salary Reduction within the time frame the contributions were not paid during the leave (provided, however, that the pre-tax dollars may not be utilized to fund coverage during the previous Plan Year).

Any arrangement approved and accepted by the Plan Administrator as permitted by Code Section 125 and the Plan Document that will be determined by the Plan Administrator will be binding on the Employee.

The Employee must choose one of these payment options before he begins his leave. If he elects to continue coverage during a leave and fails to pay the required contributions, the County may terminate his coverage. If the Employee chooses not to make contributions by one of the methods above for the period of the leave, the annual benefit amount shall be adjusted and, during the leave where no contributions are made, any expenses incurred will not be eligible for reimbursement. The Employee will be allowed to re-enroll into the Plan upon his return to work if revocation or non-payment of contributions terminated his participation. The Employee may also change his election during any Open Enrollment Period that occurs during his leave. If his coverage under a group insurance plan is terminated on account of his being in "uniformed service" and it is later reinstated, he cannot be subject to a new exclusion or waiting period requirement imposed by the Group Health Plan if the requirements would not have been imposed if coverage had not been terminated as a result of his "uniformed service."

3.8 Transfers Between Exempt Unit and other Bargaining Units

When a Participant transfers during a Plan Year between the Exempt Unit and another Bargaining Unit eligible to participate in a County Medical Expense Reimbursement Plan or vice versa, the Participant will automatically be enrolled in the Medical Expense Reimbursement Plan applicable to their new position with the same Salary Reduction.

ARTICLE IV - CONTRIBUTION

4.1 Salary Reduction Contributions

The annual benefit amount elected by the Participant is equal to the annual Salary Reduction

contribution for a Participant's benefits (for example, if the maximum $1,950 annual benefit is elected, the annual Salary Reduction amount is $1,950). The Salary Reduction for each pay period (or other period(s) mutually agreed upon) for a Participant is an amount equal to the annual Salary Reduction, divided by the number of pay periods remaining in the Plan Year, which is usually 26 for an Open Enrollment election. Salary Reductions, for the purposes of this Plan, are considered Employer Contributions under the Code.

The annual and bi-weekly maximum and minimum amounts a Participant may contribute to his Plan Account by Salary Reduction are set forth in Section 5.2.

ARTICLE V - BENEFITS AND ELECTIONS

5.1 Benefits

An election to participate in this Plan is an election to receive benefits in the form of tax-free reimbursements for Qualifying Medical Care Expenses, and to pay the contribution for such benefits via Salary Reduction.

5.2 Maximum and Minimum Benefits

The maximum bi-weekly benefit amount that a Participant, except Safety and Safety Management and Supervisory unit Participants, may receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be $75 per pay period. The maximum bi-weekly benefit amount that a Participant in the Safety or Safety Management and Supervisory unit may receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be $100 per pay period. The minimum bi-weekly benefit amount that a Participant, except Safety, Safety Management and Supervisory unit, may receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be $5 per pay period. The minimum bi-weekly benefit amount that a Participant in the Safety, Safety Management and Supervisory unit may receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be $25 per pay period. Amounts reimbursed that are attributable to Qualifying Medical Care Expenses incurred by the Participant's Spouse or Dependent shall be considered received by the Participant. For subsequent Plan Years, the maximum and minimum bi-weekly benefit amounts may be changed by the County Board of Supervisors, without amendment of this Plan Document, so long as any such changes are communicated to Employees.

5.3 Irrevocability of Election; Changes in Family Status

Except as provided in this Section 5.3, a Participant's election to participate in this Plan is irrevocable for the duration of the Plan Year to which it relates. That is, except as provided herein, for the duration of the Plan Year, the Participant may not change:

(a) His participation in the Plan;

(b) The annual benefit amount he elected; or

(c) His Salary Reduction amount.

The exception to the irrevocability requirement, permitting a mid-year election change, is as follows:

Change in Status. A Participant may revoke an existing election under the Plan and make a new election applicable for the remainder of the Plan Year upon the occurrence of a Change in Status, but only if such change is made on account of, and is consistent with, the Change in Status. The Plan Administrator shall determine whether a requested change is on account of and consistent with a Change in Status.

No Participant shall be allowed to reduce his election for Plan benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed. In addition, any change to an election affecting annual Plan contributions to the Participant's Account pursuant to this Section will also change the maximum reimbursement amount for the period of coverage remaining in the Plan Year. Such maximum reimbursement benefits for the period of coverage following an election change shall be calculated by adding the balance (if any) remaining in the Participant's Account as of the end of the portion of the Plan Year immediately preceding the change in election, to the total Plan contributions scheduled to be made by the Participant during the remainder of such Plan Year to such Account.

A Participant who has elected coverage under this Plan and who is entitled to make a new election under this Section must do so within sixty (60) days of the event. Any other new election shall be effective no sooner than the first day of the pay period immediately following the date the Participant files his new Salary Reduction agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

An Employee who is eligible to become a Participant but declined to become a Participant during the initial election period may become a Participant only during the next Open Enrollment Period, unless he experiences a qualifying event.

5.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reduction for a Plan Year if the Plan Administrator determines such action is necessary or advisable to: (i) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; or (ii) maintain the qualified status of benefits received under this Plan, including to satisfy any Nondiscrimination requirements imposed by the Code. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participants who are in the class who are designated as highly compensated employees as defined by the Code.

ARTICLE VI - REIMBURSEMENT PROCEDURE

6.1 Expenses that May be Reimbursed

The only expenses for which a Participant may receive reimbursements are Qualifying Medical Care Expenses incurred during the Plan Year for which an election is in force.

6.2 Maximum Reimbursement Available; Timing of Reimbursement

(a) *Maximum Reimbursement Available.* The maximum reimbursement amount elected by the Participant for a Plan Year (less any prior reimbursements during the Plan Year) shall be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Account pursuant to Section 6.5. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after the Participant's participation under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 6.4.

(b) *Timing of Reimbursement.* As soon as practicable after the Participant submits a reimbursement claim, the Employer will reimburse the Participant for his Qualifying Medical Care Expenses (if the claim is approved), or the Participant will be notified that his claim has been denied.

6.3 Procedure for Claiming Reimbursement

A Participant who has elected to receive benefits for a Plan Year may apply for reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year by the Participant or his Spouse or Dependent by submitting a request for reimbursement in such form as the Plan Administrator may prescribe, setting forth:

(a) The name of the person who incurred the expense, and the relationship of such person to the Participant (if such person is not the Participant);

(b) The amount, date and nature of each expense for which reimbursement is requested; and

(c) A statement that such expense has not otherwise been reimbursed and the employee will not seek reimbursement through the Group Health Plan, or any other health plan.

Such application shall be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Plan Year, no claim for reimbursement may be made unless and until the claim for reimbursement is at least $25. A Participant may file a claim no later than ninety (90) days following the close of the Plan Year in which the expense was incurred.

6.4 Termination of Benefits

When a Participant ceases to be a Participant under Article III, Section 3.3, his Salary Reductions will terminate. He will not be entitled to receive reimbursements for Qualifying Medical Care Expenses incurred after his participation terminates. However, such Participant (or his estate) may claim reimbursement for any Qualifying Medical Care Expenses incurred on or after the first day of the Plan Year and before the date his participation terminated, provided he (or his estate) files a claim no later than ninety (90) days following the close of the Plan Year in which the expense was incurred.

To the extent required by federal law (COBRA) (see Code Section 4980B), a Participant and his Spouse and Dependent, whose coverage terminates under this Plan because of a COBRA qualifying event, shall be given the opportunity to continue coverage under this Plan on an after-tax basis for the periods prescribed by COBRA and subject to all conditions and limitations under COBRA. Specifically, such individuals will be eligible for COBRA Continuation Coverage only if they have a positive Account balance at the time of a qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if eligible for COBRA Continuation Coverage. Even if COBRA is offered for the year in which the qualifying event occurs, COBRA Continuation Coverage for the Medical Expense Reimbursement Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

6.5 Establishment of Accounts

The Employer will cause to be established and maintained a Medical Expense Reimbursement Plan Account (Account) for each Plan Year with respect to each Participant who has elected to participate in this Plan, but will not create a separate fund or otherwise segregate assets for this purpose.

(a) *Crediting of Accounts.* A Participant's Account will be credited periodically during each Plan Year with an amount equal to the Participant's Salary Reductions.

(b) *Debiting of Accounts.* A Participant's Account will be debited during each Plan Year for any reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year.

(c) *Forfeiture of Accounts.* If any balance remains in the Participant's Account after all reimbursements have been made for the Plan Year, such balance shall not be carried over to the Participant's Account for the subsequent Plan Year. Instead, the Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall first be used to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing benefits) with respect to any Participant in excess of the premiums paid by such Participant via Salary Reductions, and then to reduce the Employer's cost of administering this Plan during the Plan Year. All such administrative costs shall be determined by the Plan Administrator.

ARTICLE VII - APPEALS PROCEDURE

7.1 Procedure if Benefits are Denied under this Plan

If a claim for reimbursement under this Plan is wholly or partially denied, notice of the decision shall be furnished to the claimant within a reasonable period of time, not to exceed ninety (90) days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period.

The extension notice shall indicate the special circumstances requiring an extension of time and the date on which a decision is expected to be rendered.

The written notice of denial referred to in the above paragraph shall set forth the following:

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

(b) Reference to specific Plan provisions upon which the denial is based;

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

(d) An explanation of this Plan's claims review procedure, as set forth below.

7.2 Appeals by Participant

The purpose of the review procedure set forth herein is to provide a procedure by which a claimant, under this Plan, may have reasonable opportunity to appeal a denial of a claim under this Plan to the Plan Administrator for a full and fair review. To accomplish that purpose, the claimant, or his duly authorized representative, may:

(a) Request a review upon written application to the Plan Administrator;

(b) Review pertinent Plan documents; and

(c) Submit issues and comments in writing.

A claimant (or his duly authorized representative) shall request a review by filing a written application for review with the Plan Administrator, at any time within sixty (60) days after a written

notice of the denial of his claim is mailed to the Participant.

7.3 Decision upon Appeal

Decision on review of a denied claim shall be made in the following manner:

(a) The decision on review shall be made by the Plan Administrator, who shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator receives the request for review, unless special circumstances require extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(b) The decision on review shall be written and shall include specific reasons for the decision and references to the pertinent Plan provisions on which the decision is based.

ARTICLE VIII - ADMINISTRATION OF PLAN

8.1 Plan Administrator

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

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties hereunder including, but not limited to, the following discretionary authority:

(a) To construe and interpret this Plan and to decide all questions of fact and questions relating to eligibility and participation and all questions of benefits under this Plan;

(b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) To furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) To receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) To appoint and employ such individuals or entities to assist in the administration of this

Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and

(i) To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

The Plan Administrator shall have no power to alter the terms of this Plan or to waive or fail to apply any requirements governing eligibility or participation.

ARTICLE IX - GENERAL PROVISIONS

9.1 Expenses

All administrative costs shall be borne by the Employer.

9.2 Funding this Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under this Plan may be made.

There is no trust or other fund from which benefits are paid. While the Employer has complete responsibility for the payment of benefits out of its general assets, it may hire an outside paying agent to make benefit payments on its behalf.

9.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the County may amend or terminate this Plan at any time by action of the County's Board of Supervisors, or by any person or persons authorized by the Board of Supervisors to take such action, and any such amendment or termination will automatically apply to all Participants in this Plan.

9.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of California, to the extent not superseded by the Code or other applicable federal law.

9.5 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes.

9.6 Nonassignability of Rights

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

ARTICLE X – PROVISION OF PROTECTED HEALTH INFORMATION TO EMPLOYER

10.1 Permitted Disclosures of Protected Health Information (PHI)

Unless otherwise permitted by law, and subject to obtaining written certification by Employer, on and after April 14, 2003, the Medical Expense Reimbursement Plan may disclose PHI (as defined in 45 CFR, 164.501) to the Employer solely for the purpose of enabling the Employer to perform administrative functions related to the treatment, payment and health care operations of such Plan as defined in 45 CFR, 164.501.

In no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR, 164.504(f).

10.2 Conditions of Disclosure

The Employer agrees that with respect to any PHI disclosed to it by the Medical Expense Reimbursement Plan that it shall:

Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(a) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to PHI.

(b) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer.

(c) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(d) Make available PHI in accordance with 45 CFR, 164.524

(e) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR, 164.526.

(f) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR, 164.528.

(g) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR, 164.

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

(j) Ensure that the adequate separation between the Plan and Employer, required in 45 CFR, 504(f) (2) (iii), is satisfied.

10.3 Separation between Plan and Employer

To satisfy the requirements of Conditions of Disclosure above, the following conditions shall apply.

(a) Only the following employees, or classes of employees, or other persons under control of the Employer, shall be given access to the PHI to be disclosed: Plan Administrator; Human Resources Department employees with the responsibility for Plan enrollment, claim processing, investigating questions and appeals, and recommending decisions to the Plan Administrator, employees performing Plan management and quality assessment activities, and Finance Department employees.

(b) The access to and use of PHI by the individuals described above shall be restricted to the Plan administration functions that the Employer performs for the Plan.

(c) Any individual described above who fails to comply with the provision of the Plan Document relating to the use and disclosure of PHI shall be subject to disciplinary action under the Employer's established policies and procedures.

10.4 Certification by Employer

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan Document has been amended to incorporate the provisions of 45 CFR, 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in this document. The Plan shall not disclose and may not permit a health insurance issuer or HMO to disclose PHI to the Employer as otherwise permitted herein unless the statement required by 45 CFR, 164.52.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the San Bernardino County Medical Expense Reimbursement Plan, San Bernardino County has caused this Plan to be executed in its name and on its behalf, effective July 17, 2010.

COUNTY OF SAN BERNARDINO

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Gary Ovitt, Chairman, Board of Supervisors

Dated