



## **COUNTY OF SAN BERNARDINO**

### **EXEMPT MEDICAL REIMBURSEMENT PLAN**

**Established August 28, 1999  
Amended July 27, 2002  
Amended November 18, 2003  
Amended July 19, 2005  
Amended March 25, 2008  
Amended July 17, 2010  
Amended August 23, 2011**

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## **EXEMPT MEDICAL REIMBURSEMENT PLAN**

### **ARTICLE I - INTRODUCTION**

#### **1.1 Establishment of Plan**

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

San Bernardino County (the County) hereby establishes the Exempt Medical Reimbursement Plan (the Plan or EMRP) effective August 28, 1999, as a benefit granted by the Exempt Salary Ordinance.

This amendment supersedes and replaces any prior statements of Exempt Medical Reimbursement Plan coverage for this Plan and is effective on August 23, 2011.

#### **1.2 Purpose of Amendment**

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

- A. Re-state and simplify the definition of "Dependent" at section 2.1 E.
- B. Remove reference to nonprescription drugs as an eligible medical expense at section 2.1 T.
- C. Clarify the procedure for eligible employees transferring into and out of the Exempt Medical Reimbursement Plan at section 3.14.
- D. Remove reference to Court Exempt employer matching contribution at section 4.2.
- E. Amend minimum and maximum benefit amounts at section 5.2.

#### **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 Internal Revenue Service guidance. An Employee may revoke an election, make a new election to participate in the Plan or adjust Salary Reductions for changes resulting from Change in Status Events including, but not limited to:

- (1) *Legal marital status*. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, or annulment;

- (2) *Number of Dependents.* Events that change an Employee's number of Dependents, including birth, death, adoption or placement of an adopted or foster child;
  - (3) *Employment status.* Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent:
    - (a) a termination or commencement of employment;
    - (b) a strike or lockout;
    - (c) a commencement of or return from an unpaid leave of absence.
    - (d) In addition, if the eligibility conditions of a cafeteria plan or other employee benefit plan of the employer of the Employee, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this subsection (c) (e.g., if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status);
  - (4) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for Group Benefit Plans coverage;
  - (5) *Residence.* A change in the place of residence of the Employee, Spouse, or Dependent that affects eligibility for coverage;
  - (6) *Entitlement to Medicare or Medi-Cal* (eligibility or loss of eligibility);
  - (7) *Loss of coverage under a governmental or educational health plan;*
  - (8) *Significant changes in Group Benefit Plans costs or coverage terms including the addition or elimination of a benefit plan listed on Schedule A;*
  - (9) *Commencement of or return from a leave of absence provided through the Family and Medical Leave Act (FMLA);*
  - (10) *Judgment, decree, or order* resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for an Employee's child or for a foster child who is a Dependent of the Employee; and
  - (11) *Change in Coverage under Other Employer Plan.*
- B. **Code or IRC** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.
- 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. **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.
- E. **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)). Dependent shall include any child of an employee up to the 26<sup>th</sup> birthday, without respect to marital, student, or disability status. There is no age limit in the case of a child who is totally and permanently mentally or physically disabled.
- F. **Effective Date** of this Plan means the date this plan was originally established by the County on August 28, 1999. For purposes of this Amendment, it means the date the amended and restated plan is placed into effect by the Board of Supervisors, August 23, 2011. For purposes of determining the date employment commences, it means the first regularly scheduled working day on which a new Employee performs an hour of service for the County for Compensation.
- G. **Election Period** means the period of time that an Employee has to enroll for participation in the Plan or to change an election.
  - (1) 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.
  - (2) For purposes of an Employee who becomes eligible to participate mid-Plan Year (for example, a new hire), it means 60 days from the date that the Employee became eligible (for example, the effective date of the new Employee's employment).
  - (3) For purposes of a Change in Status Event, it means 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 IRC Section 125 and the terms of this Plan. Retroactive elections are allowed only for newly hired employees that make an election within 60 days of the hire date and Health Insurance Portability and Accountability Act (HIPAA) qualifying special enrollments must be made within 30 days of a HIPAA special enrollment qualifying event. (i.e. Birth or Adoption). NOTE: Any event that results in a Dependent becoming ineligible will result in an automatic corresponding change of election under this Plan.

- H. **Employee** means an individual that the County classifies as a regular employee of the County including districts governed by the County Board of Supervisors or any entity with an agreement in place with the County to receive the benefits of this plan. Employee does not include seasonal or temporary workers as classified by the County. The term Employee does not include any employee who is eligible to participate in the Medical Expense Reimbursement Plan.

- 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. **Employer Contribution** means the contribution the Employer makes to the Accounts of Participants actively contributing to the Plan.
- K. **Exempt Medical Reimbursement (EMRP) Enrollment Form** means the form provided by the Plan Administrator for the purpose of allowing an Employee to elect to participate in the Plan by electing to receive reimbursements for Qualifying Medical Care Expenses and authorizing Salary Reductions, or to change an existing election if permitted under the Plan. At the option of the Employer, an Election Form may be created as part of a telephonic or electronic enrollment system.
- L. **Exempt Medical Reimbursement Plan Account** or **Account** means the Account established with respect to each Participant as described in Section 6.5 of this Plan.
- M. **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.
- N. **Open Enrollment** 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. **Pay Period** means the 14 consecutive calendar day period for each pay warrant issued by the County in a calendar year for payroll purposes. A Pay Period commences at 12:01 a.m. on a given Saturday and ends at 12:00 a.m. on the second Saturday thereafter. Each subsequent Pay Period commences on the succeeding Saturday at 12:01 a.m. and ends at midnight on the second Saturday thereafter. Salary Reductions pursuant to this Plan are for premiums due for the Pay Period.
- Q. **Plan** means the Exempt Medical Reimbursement Plan as set forth herein and as amended from time to time.
- R. **Plan Administrator** means the Human Resources Division Chief, Employee Benefits and Services, who is vested with the authority to administer this Plan.
- S. **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 purposes of both Salary Reduction and Claims Reimbursement.
- T. **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 over-the-counter medications unless prescribed by a physician or 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.

- U. **Salary Reduction** means the amount by which a Participant's Compensation is reduced to pay the premiums for the benefit provided under this Plan. It does not include Employer Contributions.
- V. **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**

A person is eligible to participate in this Plan if the individual is an Employee, as defined in Section 2.1 H, who is regularly scheduled to work at least 40 hours per Pay Period or be on an approved leave pursuant to the Family and Medical Leave Act. A Participant must also meet the eligibility qualifications specified in any Compensation Plan, employee contract, or Salary Ordinance governing the Employee's entitlement to Plan coverage.

- A. All Employees are subject to a Compensation Plan, employee contract or Salary Ordinance, the terms of which are incorporated herein by reference including amendments from time to time.
- B. Upon meeting the Plan eligibility requirements, an Employee may elect Salary Reduction to pay Plan premiums with before-tax Compensation dollars.

### **3.2 Determination of Eligibility by Plan Administrator**

The determination of an Employee's eligibility to participate in the Plan shall be made by the Plan Administrator. The Plan Administrator's decision shall be binding and conclusive on all persons. The Plan Administrator shall notify Employees of their eligibility to participate in the Plan and of the terms of the Plan.

### **3.3 Exempt Medical Reimbursement Plan Enrollment Form**

The Plan Administrator shall make available an Exempt Medical Reimbursement Plan Enrollment Form to Employees at the commencement of Open Enrollment via eBenefits. The Plan Administrator shall provide a newly hired Employee with a Medical Expense Reimbursement Plan Enrollment Form upon the effective date of employment.

### **3.4 Failure to Elect**

Election of before-tax payroll deductions shall be made within 60 days of the *initial* eligibility period in a manner and on such forms designated by the Plan Administrator. Failure to timely submit appropriate paperwork will result in the employee being ineligible to enroll in the Plan.

### **3.5 Election Procedures**

Employees eligible to participate in the Plan may elect to participate in the Plan and have their coverage under the Plan paid for through Salary Reduction with before-tax Compensation dollars.

- A. Open Enrollment Eligibility Period - If the Employee is making a change to their Plan election; the change must be made in a manner and on such forms designated by the Plan Administrator. If no change in election occurs, no enrollment will be made.
- B. Mid-Year Eligibility Period - An Employee who first becomes eligible to participate in the Plan mid-Plan Year including, but not limited to, newly hired Employees, Employees who satisfy the 40 hour per Pay Period requirement, Employees who satisfy other Plan eligibility requirements, or Employees who have a Change in Status Event must submit a

properly completed Medical Expense Reimbursement Plan Enrollment Form to the Plan Administrator within 60 days from the date the Employee becomes eligible to participate in this Plan or the date of the Employee's Change in Status Event. Failure to timely submit the required paperwork will result in the employee being ineligible to enroll. 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. Note: The Plan Administrator has the authority to waive the 60-day notice requirement if the Plan Administrator determines the circumstances warrant the waiver. Please see Section 2.1 G. for information regarding Election Procedures for newly hired employees.

- C. All elections during the Plan Year shall become effective beginning with the Pay Period that the properly completed Premium Deduction Election Form is received by the Plan Administrator during the applicable Election Period. Elections shall only apply to Compensation that has not yet been earned at the time of the election unless otherwise allowed under federal regulations, the Code, and this Plan.

### **3.6 Family and Medical Leave Act (FMLA)**

An Employee taking leave under the Family and Medical Leave Act (FMLA) may revoke an existing election of Plan coverage and a corresponding Salary Reduction under the Plan or make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA. The Participant may maintain Plan coverage on the same terms and conditions as if the Participant were an active Employee while on leave and shall pay for coverage with: (1) after-tax dollars by sending monthly payments to the Employer; (2) before-tax dollars by pre-paying the premium from Compensation for the expected duration of the leave through a special Salary Reduction election arranged in advance with the Plan Administrator; (3) or another acceptable arrangement between the Plan Administrator and the Participant as permitted by the Code as determined by the Plan Administrator in its sole discretion which shall be binding on the Participant. If an Employee's participation in the Plan ends because of leave under the FMLA, the Employee shall be permitted to make an election to participate upon return on the same basis as before the leave or as otherwise required by the FMLA.

### **3.7 Cessation of Participation**

A Participant will cease to be a Participant, and his or her election(s) under this Plan will be automatically revoked as of 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 or she ceases to be eligible to participate under Section 3.1;
- D. The date on which the Participant revokes an election to participate due to a Change in Status Event under Section 2.1 A.; or
- E. The date on which the Plan Administrator determines that the Participant ceases to pay premiums due on a before-tax basis under the Plan or is deemed to cease paying such premium by virtue of termination of employment.

### **3.8 Reinstatement of Former Participant**

Except as otherwise provided in the Plan, and subject to the Plan Administrator's discretion to interpret and administer the Plan, a former Participant who, during the same Plan Year, is rehired or subsequently meets the eligibility requirement of Section 3.1 above, shall be entitled to participate in the Plan as follows:

- A. If eligibility is obtained within 30 days from the date on which participation in the Plan previously terminated, the Participant must retain the same elections of Qualified Benefits that were in effect prior to said termination for the remainder of the Plan Year; or
- B. If eligibility is obtained 31 days or more from the date on which participation previously terminated, the Participant is entitled to participate in the Plan and shall be allowed to make a new election.

### **3.9 Automatic Termination of Participation**

Inability to participate in the Plan on a before-tax basis due to termination of employment and/or termination of payroll deduction(s) shall be deemed a failure to pay premiums or contributions due under the Plan. The Plan Administrator may determine cessation of participation prior to the Participant's separation from service, and such determination will result in the Participant's automatic cessation of participation under Section 3.7 of the Plan.

### **3.10 Contributions**

Salary Reductions shall be deemed Employer contributions for purposes of this Plan and the Code.

### **3.11 Plan Administrator's Discretionary Power over Elections**

The Plan Administrator may at any time require any Participant to amend the amount of his or her Salary Reduction for a Plan Year if the Plan Administrator determines such action is necessary or advisable to: (1) satisfy any Code requirements applicable to this Plan; (2) to prevent any Employee from having to recognize more income for federal income tax purposes from the receipt of benefits under this Plan than would otherwise be recognized; (3) maintain the qualified status of benefits received under this Plan; or (4) satisfy Code non-discrimination requirements or other limitations applicable to the Plan.

### **3.12 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."

### **3.13 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.

### **3.14 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 be allowed to make a new election under the new Plan, provided the new election amount selected is not less than the amount already received in the Medical Expense Reimbursement Plan applicable to their new position with the same Salary Reduction if no new election is made..

## **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. 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.

### **4.2 Employer Contributions**

The Employer may contribute Employer Contributions to a Participant's Account for each Participant who makes the minimum Salary Reduction contribution as set forth in Section 5.2. The Employer will match the contributions by the Exempt Group employees, including Elected Officials dollar for dollar, up to \$40.00 each biweekly pay period.

## **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**

Participants may contribute, on a pre-tax basis, a minimum of \$10.00 with a maximum of \$100.00 per biweekly pay period. Effective January 1, 2013, the maximum annual benefit amount (exclusive of Employer Contributions) shall be defined by federal law. 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. Should any conflict ever exist between federal law and any Compensation Plan, Salary Ordinance, or employment contract, federal law shall prevail.

### **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:

His participation in the Plan;

A. The annual benefit amount he elected; or

B. His Salary Reduction amount.

C. 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 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.
- J. 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.
- K. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing. The Agent for Service of legal process is the Department of Risk Management.

## **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:

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

- D. 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.
- E. Make available PHI in accordance with 45 CFR, 164.524
- F. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR, 164.526.
- G. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR, 164.528.
- H. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the 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.
- I. 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, on the 23rd day of August 2011.

COUNTY OF SAN BERNARDINO

\_\_\_\_\_  
Josie Gonzales, Chair, Board of Supervisors

Dated \_\_\_\_\_

