SAN BERNARDINO COUNTY

MEDICAL EXPENSE REIMBURSEMENT (FSA) PLAN

Consolidated May 5, 2015
Amended July 14, 2020

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Article I. PLAN ESTABLISHMENT

Section 1.01 Purpose

The Plan is created exclusively for Employees of San Bernardino County, 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. This Plan allows an employee to elect to obtain reimbursement for Qualifying Medical Care Expenses by making Salary Reduction contributions to the Plan on a before-tax basis.

Section 1.02 Qualification

This Plan is intended to qualify as a "Cafeteria Plan" under IRC Section 125 of the Internal Revenue Code of 1986, as amended (the Code) and the regulations issued thereunder, including, the special regulatory requirements pertaining to health flexible spending arrangements. This Plan is also intended to qualify as a "self-insured medical expense reimbursement Plan" under Section 105(h) of the Code. Further, the reimbursements of Qualifying Medical Care Expenses (as defined by IRC Section 213), are intended to be eligible for exclusion from Participant's gross income under IRC Section 105(b) of the Code.

Section 1.03 Duration of Plan

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Plan may be amended or terminated, in its entirety or by selective provision, at any time.

Section 1.04 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 manner interpreted as being in conflict with the provisions of this Plan, the provisions of this Plan shall be controlling, except when in conflict with the County's Section 125 Plan Document or the law.

Section 1.05 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.

Section 1.06 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.

Section 1.07 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.

Article II. DEFINITIONS

The following words and phrases, when capitalized shall have the following meanings.

Section 2.01 Benefit Card

The prepaid Benefit Card issued to each Participant upon enrollment in the Plan for which such Participant, their Spouse or eligible Dependent may access Medical Expense Reimbursement (FSA) Plan account funds at point of sale or service for medical expenses.

Section 2.02 Benefit Card Issuer

Benefit Card Issuer means the bank or its depository institution affiliate that issued the Benefit Card.

Section 2.03 COBRA

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

Section 2.04 Code

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

Section 2.05 Compensation

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.

Section 2.06 County

San Bernardino County, 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.

Section 2.07 Change in Status Events

The events defined by the Internal Revenue Code Section 125 that allows a Plan Participant to make changes to their benefit elections midyear and any other events that the Plan Administrator or designee, in its sole discretion, determines to be within prevailing Internal Revenue Service (IRS) guidance, Section 125 County Plan Document or stated herein.

Section 2.08 Dependent

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). Domestic Partners may qualify as a Dependent upon meeting the tax

Dependent for health coverage requirements defined in IRC Section 105(b).

1) Qualifying child shall meet the following:

    a) Is a child of the Participant or Participant's Spouse up to the 27th birthday, without respect to marital, student, or disability status; Dependents over the age of 27 qualify if they are totally and permanently mentally or physically disabled. Disabled Dependent(s) must be certified on such forms designated by the Plan Administrator or designee. Note: Child of a Participant's domestic partner is not a qualifying child.

    b) Inhabited the same residence as the Participant for more than half of the year

    c) Participant provides over one half of the qualifying child's support

    d) If married, has not filed a joint tax return

2) Qualifying relative shall meet the following:

    a) Bear a specified relationship to the Participant, such as mother, father, or descendent of any such relative

    b) Is not the qualifying child of Participant or has not been claimed by any other taxpayer for the year

    c) Gross income must be less than the exemption amount in IRC Section 151 (d)

3) Domestic Partners may qualify as a Participant's Dependent upon meeting the following:

    a) Is the Participant's state registered domestic partner

    b) Inhabited the same residence as the Participant for more than half of the year

    c) Participant provides over one half of the domestic partner's support

    d) Gross income must be less than the exemption amount in IRC Section 151 (d)

    e) Not be anyone's qualifying child

Section 2.09 Effective Date

As defined in the following circumstances:

a) Employment - the date employment commences, means the first regularly scheduled working day on which a new Employee performs an hour of service for the County for Compensation (e.g., date of hire)

b) Coverage – the date an Employee is first eligible to use the benefits of the Plan

Section 2.10 Election Period

Election period means the period of time that an Employee may make an election to participate in or change an election in the Plan.

Section 2.11 Employee

An individual that the County classifies as a regular or contract 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 benefits of this Plan. Employee does not include seasonal or temporary workers as classified by the County.

Section 2.12 Employer

Employer means San Bernardino County (the County), 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.

Section 2.13 Group Health Plan

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.

Section 2.14 Open Enrollment

Open Enrollment means the time period designated by the Plan Administrator or designee during which changes can be made for the next Plan Year, including approved changes that are made after the conclusion of the designated Open Enrollment Period, but before the beginning of the next Plan Year.

Section 2.15 Medical Expense Reimbursement (FSA) Plan Account or Account

The Medical Expense Flexible Spending Arrangement (FSA) Plan Account established and maintained for each Plan Year with respect to each Plan Participant.

Section 2.16 Medical Expense Reimbursement (FSA) Plan Enrollment Form

The form provided by EBSD or Payroll Personnel appointed by the Plan Administrator for the purpose of allowing an eligible Employee to elect to participate in the Plan. At the option of the Employer, an election form may be created as part of a telephonic or electronic enrollment system.

Section 2.17 Participant

Participant means an Employee who is participating in this Plan in accordance with the

provisions of this Plan Document.

Section 2.18 Pay Period

Pay Period means the fourteen (14) consecutive calendar day period for each pay warrant issued by the County in a calendar year for payroll purposes. There are usually twenty-six (26) pay warrants issued in a calendar year. A Pay Period commences at 12:01 a.m. on a given Saturday and ends at 12:00 a.m. midnight on the second Friday thereafter. Each subsequent Pay Period commences on the succeeding Saturday at 12:01 a.m. and ends at 12:00 a.m. midnight on the second Friday thereafter.

Section 2.19 Plan

Plan means the Medical Reimbursement (FSA) Plan as stated herein and as amended from time to time.

Section 2.20 Plan Administrator

Plan Administrator means the Human Resources Division Chief, Employee Benefits and Services Division (EBSD), or designee, who is vested with the authority to administer this Plan. The Plan Administrator shall be responsible for managing and directing the operation and administration of the Plan.

Section 2.21 Plan Contribution

Plan Contribution means the Participant's Salary Reduction or Employer Contribution amount paid to the Participant's account. Under this Plan, Salary Reductions shall be deemed Employer contributions for purposes of the Code.

Section 2.22 Plan Year

Plan Year means the 12-month period that commences 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 Reductions and claims reimbursement.

Section 2.23 Qualifying Medical Care Expense

An expense incurred by a Participant, or by the Spouse or Dependents of such Participant, for medical care as defined in Section 213 of the Code, 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 a Group Health Plan, other insurance, other accident or health Plan, for expenses in which they claim a federal tax credit, or any other source.

A medical expense is incurred at the time the medical care or service which gave rise to the

expense is rendered, and not when the Participant is formally billed.

Section 2.24 Salary Reduction Agreement

Salary Reduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Plan benefits.

Section 2.25 Salary Reduction Contributions

Salary Reduction Contributions means the contributions taken from the Participating Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

Section 2.26 Spouse

Spouse means an individual who is legally married to a Participant and who is treated as a Spouse under the IRC Section 152.

Article III. BENEFITS AND ELIGIBILITY

Section 3.01 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 Contributions.

Section 3.02 Eligibility

A person is eligible to participate in this Plan if the individual is an Employee, as defined in the Plan. An Employee must also meet the eligibility qualifications specified in any Memoranda of Understanding, Compensation Plan, Employment Contract, or Salary Ordinance governing the Employee's entitlement to Plan coverage, the terms of which are incorporated herein by reference including amendments from time to time.

The determination of an Employee's eligibility to participate in the Plan shall be made by the EBSD Personnel appointed by the Plan Administrator or designee. Such determinations shall be binding and conclusive on all persons.

Section 3.03 Reinstatement of Former Participant

A former Participant who returns to County service in the same Plan Year, shall be eligible to participate in the Plan provided such Employee satisfies the eligibility requirements of the Plan. Notwithstanding the foregoing, if a former Participant is:

a) **Rehired within 30 days or less from termination date:** the Participant may make an election to reinstate a level of coverage that is equivalent to the level of coverage elected prior to termination of employment, reduced by the amount of contributions missed during the period of termination.
b) **Rehired after 30 days or more from termination date:** the Participant may make a new prospective election. Under no circumstances shall the Participant's collective elections (prior and new election amounts) exceed the annual Salary Reduction limit defined in IRC Section 125.

Article IV. ELECTIONS

Section 4.01 Election to Participate

An Employee who has elected to participate in this Plan may make Salary Reduction for Plan coverage with before-tax compensation dollars. 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. The election to participate in the Plan must be made in a manner and/or on such forms (paper or electronic) designated by the Plan Administrator or designee. Failure to timely submit an appropriate election request will result in the Employee being ineligible to enroll in the Plan.

Section 4.02 Election Period

An Employee may make an election to participate in the Plan or to change a Plan election during the following Election Periods:

a) Open Enrollment - the time period designated by the Plan Administrator or designee during which an Employee can make an election to participate in the Plan for the Plan Year.

b) Change in Status Event – the time period during which a Participant or Newly Eligible Employee (e.g. New Hire) may make a new or change a current Plan election outside of the Open Enrollment Period in accordance with IRC Section 125, the County's Section 125 Plan Document and stated herein. A Participant has sixty (60) days from the date of the Qualifying Change in Status Event to submit an election request to EBSD.

With the exception of the retroactive events listed below, in accordance with IRC Section 125, coverage will be made effective on a prospective basis. Pursuant to the terms of the County's Section 125 Plan Document and stated herein, elections generally will be made effective the first Pay Period following the date in which the required elections forms are received by EBSD.

a) Retroactive elections for the events listed below will be made effective the first Pay Period following the date of the event so long as the Change in Status Request is received by EBSD within 30 days of the event.

    a. New Hire

    b. HIPAA Special Enrollment Section 125 Change in Status Events (e.g. Birth or Adoption)

Section 4.03 Supplemental Elections

The Plan Administrator may approve a supplemental election to correct an enrollment or election form or Salary Reduction Agreement that is invalid for any reason if approval would not violate Code Section 125.

Section 4.04 Enrollment

The EBSD or Payroll Personnel appointed by the Plan Administrator shall make available a Medical Reimbursement (FSA) Plan Enrollment Form to eligible Employees during the following Election Periods:

a) Open Enrollment

b) Change in Status Events, including but not limited to periods of initial eligibility for participation in the Plan (e.g. New Hire or Extra Help to Regular status)

Section 4.05 Participant Certification

A Participant who has elected to receive benefits under this Plan will receive a Benefit Card to access funds from their FSA account for qualifying medical care expenses at point of sale or service. By completing the designated FSA Enrollment Form and upon each use of the Benefit Card, Participant agrees that they will:

a) only use the card to pay for their, their Spouse's or eligible Dependent's medical care expenses;

b) only use the card to pay for medical expenses that have not otherwise been reimbursed;

c) not seek reimbursement under any other health or flexible spending arrangement Plan for expenses paid for with the card;

d) acquire and keep supporting documentation (e.g. receipts or statements of service) for expenses paid with the card as set forth in IRS Revenue Procedure 98-25; and

e) abide by and maintain responsibility for the use of card as specified in the Benefit Card Cardholder Agreement and the Plan stated herein, including but not limited to the following:

    a. Benefit Card Issuance, Retention, and Funding: Two Benefit Cards will be issued to a Participant upon enrollment in the Plan. Participant may order an additional set of cards. Additional fees for card issuance will be charged to the Participant and expensed from Participant's FSA Account as a Qualifying Medical Expense. Participant will not be able to order additional cards if adequate account funds are not available to cover fees.

i. The Benefit Card will be funded with the annual benefit amount elected by Participant

ii. Participant shall retain the same Benefit Card for three (3) Plan Years

b. Card Activation: Participant shall activate the Benefit Card upon receipt. Activation of the Benefit Card is considered acceptance of the terms and conditions set forth in the Benefit Card Cardholder Agreement.

c. Authorized User: Participant may only share their Benefit Card or Benefit Card Number with their Spouse or Dependent defined herein. If Participant permits Spouse or eligible Dependent to access Benefit Card or Benefit Card Number, Participant will be liable for all authorized transactions.

d. Authorized Transaction: Participant is responsible for the use of the Benefit Card, including all transactions incurred by use of the Benefit Card. Benefit Card use by Participant, Spouse or eligible Dependent constitutes Participant's authorization of transaction.

e. Unauthorized Use: Participant shall not authorize use of Benefit Card or authorize transactions for an individual who does not meet Dependent eligibility requirements stated herein.

f. Unauthorized Transactions or Transaction errors: Participant shall report any unauthorized transactions (e.g. fraudulent) or transaction errors to EBSD and the Benefit Card Issuer. Participant may dispute unauthorized transactions or transaction errors by submitting a completed Activity Dispute form to the Benefit Card Issuer.

Section 4.06 Irrevocability of Election

A Participant's election to participate in the Plan is irrevocable for the duration of the Plan Year to which it relates, unless the Participant experiences a qualifying IRC Section 125 event. Except as provided under IRC Section 125, the Participant may not change their (i) election to participate in the Plan; (ii) annual benefit election amount; or (iii) Salary Reduction contribution amount for the duration of the Plan Year.

Section 4.07 Forfeitures

A Participant shall forfeit unused Plan Contributions in their FSA Account as of the close of the Plan Year. Amounts forfeited by Participants shall become general assets of the County and used at its sole discretion. If any balance remains in the Participant's account due to an uncashed check or failed direct deposit, such balance will forfeit to the County.

The Plan shall consider all benefits deemed paid but any checks that have not been claimed

or cashed within six months after the close of the Plan Year will be forfeited.

Section 4.08 Rollover of Funds

Notwithstanding the foregoing and in accordance with the provisions set forth in the Participant's applicable Memoranda of Understanding, Employment Contract, or Salary Ordinance, a Participant shall not forfeit unused Plan Contributions applicable to the Medical Expense Reimbursement (FSA) Plan that do not exceed the established IRS rollover amount or the unused balance of such Participant's FSA Plan account at the close of the Plan Year (after the claim run out period). The Plan will automatically rollover/carryover the established IRS rollover amount, if less, the unused balance in his FSA Plan account at the close of the Plan Year to the next subsequent Plan Year contingent upon enrollment in the next Plan Year. Such unused balance cannot be cashed out. Funds will only rollover one time into the subsequent Plan Year. Any amounts in excess of the established IRS rollover amount shall be forfeited in the same manner as forfeitures for other Plan Contributions.

Section 4.09 Midyear Change in Status

In accordance with IRC Section 125, a Participant may request to revoke an election, make a new election, or change an existing election for Plan coverage for changes resulting from and that are consistent with a qualifying Change in Status Event. Change in Status Requests must be made in a manner and/or on such forms designated by the Plan Administrator or designee. Requests for Change in Status must be received by EBSD within sixty (60) days from the date of the Change in Status Event. Failure to timely submit the required paperwork will result in the Participant being ineligible to make or change an election. If the last day of the sixty (60) days falls on a holiday or weekend, the enrollment period shall be extended to the next business day. Note: The Plan Administrator or designee has the authority to waive the 60-day notice requirement if the Plan Administrator or designee determines the circumstances warrant the waiver.

a) Qualifying Change in Status Events include, but are not limited to:

    a. Legal marital status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, or annulment;

    b. Number of Dependents. Events that change an Employee's number of Dependents, including birth, death, adoption or placement of an adopted or foster child;

    c. Employment status. Events that change an Employee's or Employee's Spouse's employment status resulting in a change in eligibility for participation in the County or other employer health Flexible Spending Arrangement (FSA) Plan. Events include, but are not limited to the following:

i. A termination or commencement of employment;

ii. A strike or lockout to the extent it causes a change in work hours, loss of eligibility or wages;

iii. A change in employment status that changes Plan eligibility for Participant or Participant's Spouse (e.g. Employee switches from a contract position that is not FSA eligible to a regular position that is FSA eligible. This change would be consistent with initial eligibility for FSA Plan participation.)

d. Commencement of or return from a leave of absence provided through the Family Medical Leave Act (FMLA);

e. Commencement of or return from an unpaid leave of absence;

f. Dependent satisfies or ceases to satisfy Dependent eligibility requirements for the County's FSA Plan;

g. Change in residence. A change in the place of residence of the Employee or Dependent that affects eligibility for Plan coverage;

h. Entitlement to Medicare or Medicaid/Medi-Cal. Entitlement to Medicare or Medicaid/Medi-Cal means that an Employee, Employee's Spouse or Dependent becomes entitled to coverage (i.e. becomes enrolled) under Part A or Part B of Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act. For purposes of this Plan, Entitlement to Medicare or Medicaid/Medi-Cal is as follows:

i. Entitlement to Medicare includes an Employee or Employee's Spouse who has reached 65 years of age and has enrolled in coverage to receive Medicare benefits.

ii. Entitlement to Medicaid/Medi-Cal includes the Employee or Employee Spouse's Dependent who has enrolled in coverage to receive Medicaid/Medi-Cal benefits.

i. Significant change in cost of coverage. A significant change in cost of medical care expenses for Participant, Participant's Spouse or dependent. Significant is defined as an increase in costs that is ten percent (10%) or greater.

j. Judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including qualified medical child support order) that requires accident or health coverage for an Employee's Dependent under the Employee's Plan or an order that requires Spouse,

former Spouse or other individual to provide coverage for the Dependent .

k. Effective as of January 1, 2020 through the end of the 2020-21 plan year, the plan will allow for the following Midyear Change in Status Events:

    i. Employees who waived coverage in the Medical Expense Reimbursement Plan may elect coverage for the remainder of the plan year irrespective of whether they experienced a Midyear Change in Status event.
    Employees who elected Medical Expense Reimbursement Plan coverage, may cancel their enrollment entirely or change their election irrespective of whether they experienced a Midyear Change in Status event. This means that employees may increase their election amount up to the allowable plan maximum or decrease their election amount but by no more than the greater of the contributions made or reimbursements received as of the date of the election change request. Medical Expense Reimbursement Plan elections may only be decreased or cancelled if the Participant has an account balance.

Section 4.10 Establishment of Accounts

The Employer will establish and maintain a Medical Expense Reimbursement (FSA) Plan Account each Plan Year for each Plan Participant, but will not create a separate fund or otherwise segregate assets for this purpose.

A Participant's Account will be credited periodically during each Plan Year with an amount equal to the Participant's Salary Reductions.

A Participant's Account will be debited during each Plan Year for any reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year.

Article V. CONTRIBUTIONS

Section 5.01 Minimum and Maximum Contributions

Participants may contribute, on a pre-tax basis, the minimum and maximum contribution amount specified in any applicable Memoranda of Understanding, Compensation Plan, Salary Ordinance, or Contract which governs the Employee's entitlement to Plan coverage. The minimum and maximum 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 a conflict exist between the IRC and any Memoranda of Understanding, Compensation Plan, Salary Ordinance, or Employment Contract, the IRC shall prevail.

Section 5.02 Participant Salary Reduction Contributions

As a condition of Plan participation, Employees must agree to direct their Employer to reduce their compensation and make Salary Reduction Contributions to the plan(s) governing their selected County-sponsored Benefit Plan Premium(s).

Any election of a County-sponsored Benefit Plan shall be null and void unless the Employee authorizes a Salary Reduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and apply them as directed. Any such Salary Reduction Agreements acknowledges Employees agreement to adhere to the provisions of the Plan.

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 deemed Employer Contributions under the Code.

The Plan Administrator or designee 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 or designee determines such action is necessary or advisable to:

a) Satisfy any Code requirements applicable to this Plan

b) 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;

c) Maintain the qualified status of benefits received under this Plan, including to satisfy any Nondiscrimination requirements or other limitation applicable to the Plan;

d) In the event contributions need to be reduced for a class of Participants, the Plan

Administrator or designee 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.

Section 5.03 Employer Contributions

Employer Contributions, if any, shall be provided in accordance with the terms and conditions of an Employee's applicable Memoranda of Understanding, Compensation Plan, Employment contract, or Salary Ordinance governing the Employee's entitlement to such Employer Contributions.

Notwithstanding any contrary Plan provision, an Employer is not obligated to contribute to the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

Section 5.04 Priority of Contributions

Priority of Contributions shall be determined by the Employer.

Article VI. LEAVES OF ABSENCE

In accordance with IRC Section 125 and this Plan document, a Participant taking a leave of absence under the Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), or an unpaid non-FMLA leave of absence may revoke or continue Plan coverage. The Participant may maintain Plan coverage on the same terms and conditions as if the Participant were an active Employee while on leave. The Participant will be allowed to re-enroll into the Plan upon their return to work if revocation or non-payment of contributions terminated their participation. The Participant may make a new election during any Open Enrollment Period that occurs during their leave.

Section 6.01 Types of Leave of Absence

Family Medical Leave Act (FMLA): an unpaid or paid leave of absence (with integration of paid leave accruals) that allows eligible Employees to take a limited amount of unpaid, job protected leave in accordance with the Family Medical Leave Act.

Non-FMLA Leaves of Absence: an unpaid special leave of absence that allows eligible Employees to take limited amount of approved unpaid non-FMLA leave of absence or paid disability leave in accordance with the Employee's Memoranda of Understanding, Compensation Plan, Salary Ordinance, or Employment Contract.

Uniformed Service Leave of Absence: an unpaid or paid leave of absence that allows eligible Employees to take a leave of absence on account of being in "uniformed service" as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and in accordance with the Employee's Memoranda of Understanding, Compensation Plan, Salary Ordinance, or Employment Contract.

Section 6.02 Leave of Absence Election Options

Commencement of Leave: While on an approved leave of absence Participants may make the following Plan elections:

Revocation of Coverage: a Participant may elect to revoke Plan coverage by submitting Change in Status Request Forms to EBSD upon commencement of an approved leave of absence. Plan coverage will terminate the first day of the Pay Period following the date in which EBSD receives the Change in Status Request for Revocation or the first day of the Pay Period in which the Participant's Salary Reductions cease, whichever comes first. The Participant will not be eligible for reimbursement for expenses incurred after the date of termination or for the duration of the Pay Period in which a Salary Reduction was not received by EBSD.

Continuation of Coverage: a Participant may elect to continue Plan coverage by submitting

the Continuation of Benefits Designation Form to EBSD prior to or upon the commencement of a leave of absence. Participant may elect to pay for coverage under the following options:

a) Prepayment: Prior to the commencement of leave, a Participant may elect to pay Plan Contributions for all or part of the expected duration of the leave through a Salary Reduction on the first day of the first pay period following receipt of the Prepayment election or if election requests are not submitted timely, a lump sum Salary Reduction will be taken from the Participant's final pre-leave pay warrant to the extent allowable by law. Prepayment may also be made directly to EBSD with after-tax dollars. Pre-payments received by the Plan that are not equivalent to the full duration of the leave shall be made in a manner that maintains Plan coverage for periods that are equivalent to the duration of a Pay Period. The Participant will not be eligible for reimbursement for expenses incurred during Pay Period(s) for which the Participant's Salary Reductions were not received by EBSD.

b) Bi-weekly Payment: Prior to or upon commencement of leave, a Participant may elect to pay Plan Contributions each Pay Period for all or part of the expected duration of the leave either through Salary Reductions (to the extent available) or with after tax dollars.

c) Alternate Payment: The Plan Administrator or designee may permit a Participant to make payment under an alternative payment arrangement as permitted by the IRC Section 125 and the Plan Document. Any arrangement approved and accepted by the Plan Administrator or designee will be binding on the Participant.

Failure to make payment under any of the aforementioned options will result in termination of Plan coverage. Termination will be made effective the first day of the Pay Period for which payment was not received. The Participant will not be eligible for reimbursement for expenses incurred after the date of termination or the first day of the pay period in which the Participant's Salary Reductions ceased or were not received by EBSD, whichever comes first.

Return from Leave: Upon return from an approved leave of absence Participants may make a new election to participate in Plan coverage if coverage terminated due to revocation or failure to make payment while on leave of absence. New elections are available under the following coverage options:

a) Prorated Coverage: Participant may elect to reinstate a level of coverage that is equivalent to the level of coverage elected prior to commencing leave, reduced by the amount of contributions missed during the leave. Under no circumstance shall the Participant's new election amount exceed the annual election amount on file prior to the leave of absence or the annual Salary Reduction limit pursuant to IRC Section 125.

b) Reinstatement of Original Coverage: Participant may elect to reinstate a level of coverage that is equivalent to the level of coverage elected prior to commencing leave. Under this option, Participant's Salary Reduction will be increased to include contributions missed during the leave of absence. Under no circumstance shall the Participant's new election amount exceed the annual election amount on file prior to the leave of absence or the annual Salary Reduction limit pursuant to IRC Section 125.

Section 6.03 Qualified Reservist Distribution (QRD)

In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), Participants who are a member of a reserve component (as defined in 37 U.S.C. §101) ordered or called to active duty for a period of 180 days or more *or* for an indefinite period, may elect to request a QRD of the funds in their FSA Account.

QRD Election Amounts: Election amounts must be equivalent to the amount contributed by Participant to their FSA Account minus the amount of received reimbursements as of the date the QRD request is received by EBSD. A QRD may only be made with respect to a Participant's current FSA balance; prior Plan Year fund balances are not eligible for disbursement. QRD requests may only be made once each Plan Year. Upon election of a QRD, the Participant's Plan coverage will terminate for the remainder of the year, unless a qualifying event is experienced that allows reinstatement of Plan coverage (e.g., return from leave). The Participant will not be eligible for reimbursement for claims for expenses incurred after the date of the QRD request. To account for Participant's current contributions, QRD requests will become effective the first day of the Pay Period following the date the QRD is received by EBSD. QRD amounts are subject to taxation; paid amounts will be included in the Participant's gross income and wages.

QRD Requests: Participant may request to elect a QRD by submitting forms designated by the Plan Administrator or designee and order of call or duty to EBSD on or after the date of order or call to active duty, but no later than the last day of the Plan Year during which the order or call to active duty occurred.

QRD Fund Disbursement: EBSD will distribute funds as soon as possible, but no later than sixty days of receipt of QRD request.

Article VII. REIMBURSEMENT PROCEDURE

Section 7.01 Expenses that May be Reimbursed

The only expenses for which a Participant may receive reimbursements are Qualifying Medical Care Expenses (as defined by IRC Section 213), which are incurred during the Plan Year for which an election is in force.

Section 7.02 Maximum Reimbursement Available (Uniform Coverage)

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.

Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after the Participant's election under this Plan has terminated, unless the Participant has elected COBRA. 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.

Article VIII. CLAIMS REIMBURSEMENT

Section 8.01 Claims Reimbursement Request

A Participant who has elected to receive benefits may apply for reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year by the Participant, or his Spouse or Dependent by timely submitting a properly completed paper or electronic claim (includes supporting documentation) for reimbursement of Medical Care Expenses, setting forth:

a) The name of the person who incurred the expense (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.

d) A Participant may file a claim no later than ninety (90) days following the end of the Plan Year (last day of Plan Year) in which the expense was incurred.

    a. For the purposes of plan year 2019-20 only, the deadline for submitting Medical Expense Reimbursement Plan claims has been extended until December 31, 2020.

Section 8.02 Claim Submission via Benefit Card

A Participant may pay for Qualifying Medical Care Expenses incurred by Participant, Participant's Spouse, or Dependent by Benefit Card at Point of Sale or Service. For purposes of this Plan, Benefit Card transactions are considered a claim for expenses incurred. Benefit Card Transactions are subject to the same supporting documentation and claims processing requirements set forth herein.

Section 8.03 Requests for Documentation

Claims for reimbursement shall be accompanied by bills, invoices, or other statements from an independent third party supporting claimed expenses, together with any additional documentation requested by EBSD Personnel appointed by the Plan Administrator.

Responses to requests for documentation provided by the EBSD must be made within 30 days of receipt. Failure to provide necessary documentation to EBSD Personnel appointed by the Plan Administrator will result in denial of the claim.

Section 8.04 Claims Processing Procedure

Within 30 days after receipt of a properly completed and timely submitted written or electronic claim (including supporting documentation) for reimbursement of Medical Care Expenses, the EBSD Personnel appointed by the Plan Administrator shall adjudicate the claim as follows:

a) If the claim is determined to be eligible for reimbursement, the EBSD Personnel appointed by the Plan Administrator shall reimburse the Participant for the amount of the claim that is subject to coverage under the Plan. The reimbursement shall be paid from the Participant's FSA Account.

b) If it is determined that additional information from Participant is required to substantiate the claim, a request for more information shall be furnished to the Participant 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. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period.

c) If a claim for reimbursement under this Plan is wholly or partially denied, notice of the decision shall be furnished to the Participant 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. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period.

d) The specific reason or reasons for the request for more information or denial shall include a description of any additional documentation or information necessary for the Participant to perfect the claim and an explanation of why such documentation or information is necessary. The written notice of denial shall advise Participant of this Plan's appeal procedure. Note: additional information necessary to perfect the claim must be furnished to the EBSD within 30 days of a request for more information or the date the denial notification.

e) The 30-day reimbursement period may be extended an additional 15 days by the Plan Administrator or designee for matters beyond the control of the Plan to complete adjudication of a claim. The Plan Administrator or designee shall have sole discretion whether to extend the time.

With respect to the use of debit cards, the following additional rules will apply:

a) For non-health care vendors, automatic substantiation will apply only if the vendor uses an inventory control system;

b) For health care vendors, automatic substantiation will apply if:

a. The vendor uses an inventory control system;

b. Expenses are the exact multiples of the Plan's copayments (up to five times the copayment dollar amount);

c. Expenses are the same as a previously approved claim with regard to claim amount, medical care provider, and time period (e.g., recurring claim). Any variance of information from a previously approved claim will not be automatically substantiated and subject to claims processing requirements herein; or

d. Expenses are accompanied by supporting documentation from a third party that verifies in real-time that claim is eligible for reimbursement at point of sale (e.g., prescription for OTC presented at pharmacy).

c) For drug store and pharmacies (even if classified as health care vendors), the automatic substantiation provisions above apply only if either of the following apply:

a. 90% of their gross receipts are from qualified medical expense items; or

b. They use an inventory control coding system.

Article IX. APPEALS PROCEDURE

Section 9.01 Appeals by Participant

The purpose of the appeal 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 EBSD – Appeals Unit appointed by the Plan Administrator or designee for a full and fair review. To accomplish that purpose, the Participant may:

a) Request a review by the next level reviewing authority to review a decision upon written appeal;

b) Review pertinent Plan documents; and

c) Submit issues, comments, rebuttals along with additional/relevant documentation, not previously provided, in writing.

d) A claimant shall request a review at any time within sixty (60) days after written notice of denial mailed to the Participant.

Appeals may be submitted to:

San Bernardino County Human Resources Department
Employee Benefits and Services Division
157 W. Fifth Street, First Floor
San Bernardino, CA 92415-0440
Attn: Appeals Unit

Section 9.02 Decision upon Appeal

Appeal decision of a denied claim shall be made in the following manner:

a) The appeal decision shall be made by the EBSD – Appeals Unit appointed by the Plan Administrator, who shall make a decision promptly, but not later than sixty (60) days after the EBSD – Appeals Unit 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.

b) The appeal decision 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 X. TERMINATION

Section 10.01 Termination of Participation

A Participant will cease to be a Participant, and his or her election(s) under this Plan will be automatically terminated as of the earliest of:

a) The end of the Plan Year for which he has elected to participate;

b) The date on which the Plan terminates;

c) The date on which he or she ceases to be eligible to participate under the Plan;

d) The date on which the Participant revokes an election to participate due to a Change in Status Event;

e) The date the Participant ceases to make Salary Reduction contributions by virtue of termination of employment; or

f) The date on which the EBSD Personnel appointed by the Plan Administrator determines that the Participant ceases to be eligible as a result of failing to make Salary Reduction contributions.

Section 10.02 Effects of Termination of Participation

Termination of Participation under the FSA Plan automatically cancels the Participant's Salary Reduction Agreement on the date coverage terminates. The applicable Plan's terms control whether and to what extent coverage and benefits under the FSA Plan continue.

Section 10.03 Termination of Benefits

The Participant will not be entitled to receive reimbursements for Qualifying Medical Care Expenses incurred after their participation terminates. However, such Participant or Participant's Surviving Spouse and Surviving Adult Dependent (if Participant is unmarried) 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 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 or his Surviving Spouse and Adult Dependent, whose coverage terminates under this Plan, 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 their available balance, less any funds reimbursed, is greater than the COBRA premium (remaining contributions, plus 2% fee) as of the date of termination of employment or last

Salary Reduction received by EBSD, whichever is later. Such individuals will be notified if eligible for COBRA Continuation Coverage. If elected, COBRA Continuation Coverage for the Medical Expense Reimbursement (FSA) Plan will cease at the end of the Plan Year in which Qualifying Event occurred and cannot be continued for the next Plan Year.

Article XI. ADMINISTRATION OF PLAN

Section 11.01 Plan Administrator

The Human Resources Division Chief, Employee Benefits and Services Division (EBSD), or designee, who is vested with the authority to administer this Plan, shall be the Plan Administrator of the County's Medical Expense Reimbursement (FSA) Plan.

Section 11.02 Plan Administrator's Duties

The Plan Administrator or designee shall:

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

b) 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;

c) Sign documents for the purposes of administering this Plan, or designate an individual or individuals to sign documents for the purposes of administering this Plan;

d) Allocate and delegate its responsibilities under the Plan and designate other persons to carry out any of its responsibilities under the Plan;

e) Notify Employees eligible to participate in the Plan of:
   a. The Plan's availability and terms,
   b. The County-sponsored Benefit Plan available for election and corresponding premium,
   c. The maximum annual Salary Reduction Contribution amounts for each available County-sponsored Benefit Plan, and
   d. The procedures for enrolling and making and changing elections;

f) Supply eligible Employees with any forms and agreements they must complete;

g) Maintain the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

h) Receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator or designee determines from time to time to be necessary and proper;

i) Maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and meet any applicable disclosure and reporting requirements;

j) Allocate and delegate its responsibilities under the Plan and designate other persons to carry out any of its responsibilities under the Plan;

k) Manage and carry out the Plan's operation and administration according to the Plan's terms and for Covered Employees' exclusive benefit.

Section 11.03 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

a) Require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;
b) Make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;
c) Interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;
d) Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;
e) Determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;
f) Determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part; provided however, that any claim for benefits under a health and welfare plan shall be determined solely in accordance with the terms of such plan;
g) Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;
h) Adjust salary reductions resulting from an increase or decrease in the premiums during the Plan Year;
i) Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

j) Make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including such amendments as may be required or appropriate to satisfy the requirements of the Code and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

k) Pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

Section 11.04 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

Article XII. AMENDMENT, TERMINATION OR MERGER OF PLAN

Section 12.01 Right to Amend the Plan

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 actions, and any such amendment or termination will automatically apply to all Participants in this Plan. No amendment, modification or termination will reduce retroactively the benefits of any Participant under the Plan to the extent such amounts are payable under the terms of the Plan in compliance with the Code as determined by the Plan Administrator that are in effect prior to the Pay Period for which the Plan is terminated or amended. Any amendment or termination shall take effect only at the end of a Pay Period, subject to the Plan Administrator's power to administer this Plan. The County shall adopt amendments in writing, including the date of adoption, signed by its duly authorized officers. The amendments, if appropriate, shall be attached to this Plan or the Plan shall be restated and amended in its entirety, as the County shall determine is appropriate.

Article XIII. MISCELLANEOUS

Section 13.01 No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

Section 13.02 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. This Plan is not a guarantee of continuation of any benefits or coverage offered through the Plan.

Section 13.03 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

Section 13.04 No Assignment of Benefits

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to affect same shall be void.

Section 13.05 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously or in excess to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

Section 13.06 Section Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

Section 13.07 Misrepresentation or Fraud

A Covered Employee who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

Section 13.08 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

Section 13.09 Funding this Plan

All amounts payable under this Plan shall be paid from the general assets of the Employer. The County shall pay all plan expenses. 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.

Section 13.10 Expenses

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

Section 13.11 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. The current amendment supersedes and replaces any prior statements for the Medical Expense Reimbursement (FSA) Plan.

Section 13.12 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.

Section 13.13 No Guarantee of Tax Consequences

Neither the Plan Administrator or designee 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.

Section 13.14 Limitation on Liability

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, shall be construed as giving to any Participant or other person any legal or equitable rights against the County, the Plan or the Plan Administrator or designee, except as expressly provided herein or as provided by applicable federal law.

Section 13.15 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.

Section 13.16 Notices

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

Section 13.17 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

Section 13.18 Disclaimer

The Employer makes no assertion or warranty about:

a) whether Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or
b) Whether any other tax treatment is or will be applicable.

Section 13.19 Data

Each Participant must furnish the County such documents, evidence, or information as the County considers necessary or desirable for the purpose of administering the Plan or to

protect the County or other organization or institution providing benefits under the Plan. Evidence required of anyone under the Plan shall be signed, made, or presented by the proper party or parties and may be a certificate, affidavit, document or other information that the person acting thereon considers pertinent and reliable.

Section 13.20 Mistake of Fact

Any mistake of fact or misstatement of fact that is supported by clear and convincing evidence shall be corrected when it becomes known and proper adjustment made by reason thereof.

Section 13.21 Withholding for Taxes

Notwithstanding any other provision of the Plan, the County or institution providing Medical Care Expenses may withhold from any payment to be made such amount or amounts as may be required for purposes of complying with the tax withholding provisions of the Code, any state's income tax act, or any other applicable laws.

Section 13.22 Tax Effects

Neither the County nor the Plan Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Participant hereunder will be treated as excludable from gross income for state or federal income tax purposes.

Section 13.23 Employees' Tax Obligations

a) Excludability Determination
    i. Covered Employees themselves must determine whether Plan benefits are excludable for tax purposes, and must notify the Plan Administrator if they have reason to believe a payment is not excludable.
b) Liability and Payment
    i. If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan does not qualify as a cafeteria plan under Code section 125 for the Plan Year, then Covered Employees must:
        1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions, and
        2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the

excess Salary Reduction Contributions or other Employer contributions been treated as taxable income.

Section 13.24 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 (FSA) 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).

Section 13.25 Conditions of Disclosure

The Employer agrees that with respect to any PHI disclosed to it by the Medical Expense Reimbursement (FSA) 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.

Section 13.26 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 or designee; Human Resources Department Employees with the responsibility for Plan enrollment, claim processing, investigating questions and appeals, and recommending decisions to the Plan Administrator or designee; 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 whom 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.

Section 13.27 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.

Section 13.28 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

Section 13.29 Entire Agreement

This document or documents expressly incorporated by reference or attached hereto sets forth the entire Plan. Except as provided in this Plan, no other employee benefit plan, which is or may hereafter be maintained by the County on a non-elective basis, shall constitute a part of this Plan.

IN WITNESS WHEREOF, San Bernardino County has executed this Plan Document effective July 14, 2020.

SAN BERNARDINO COUNTY

_____

Curt Hagman, Chairman, Board of Supervisors

Dated: _____