

**PLACER COUNTY**  
*Amended and Restated*  
**TAHOE AREA**  
**HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")**

Original Effective Date: January 1, 2001

**The effective date of this document is January 1, 2008.**

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## **PREAMBLE**

Effective January 1, 2001, **PLACER COUNTY** established this **TAHOE AREA HEALTH REIMBURSEMENT ARRANGEMENT** (the "HRA") for the:

- the employees of the Placer County Deputy Sheriffs Association (PCDSA), and
- the employees of the Placer Public Employees Organization, (PPEO), and
- the employees of the Management & Confidential Team,

whose position assignments are in the Tahoe area, for purposes of providing reimbursement of Eligible Medical Expenses incurred by Participants and/or Covered Dependents in accordance with the terms of this Document and the Summary Plan Description, which has been incorporated into and made a part of this document. The HRA is intended to qualify as a medical expense reimbursement plan under Internal Revenue Code Section 105.

**PLACER COUNTY**  
***Amended and Restated***  
**TAHOE AREA**  
**HEALTH REIMBURSEMENT ARRANGEMENT ("HRA" or "Plan")**

**ARTICLE I**  
**DEFINITIONS**

**1.01 "Affiliated Employer"** means any entity that is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

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

**1.03 "Benefits Administrator"** means Fringe Benefits Management Company (FBMC), which has agreed to perform certain services on behalf of the Plan Administrator as set forth in the FBMC Plan Services Agreement.

**1.04 "Board of Supervisors"** means the Board of Supervisors or other governing body of the Employer (the "Board"). The Board of Supervisors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

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

**1.06 "Component Medical Plan"** means the comprehensive accident and health plan sponsored by the Employer which, as set forth in the enrollment materials for the applicable Plan Year ("enrollment materials"), must be elected to obtain HRA Dollars under this Plan. This HRA shall be considered with the Component Medical Plan to be a single employee welfare benefit plan.

**1.07 "Covered Dependent"** means a Dependent who becomes covered by the Plan in accordance with the terms of the Plan's Summary Plan Description.

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

**1.09 "Effective Date"** of this Plan means January 1, 2001. This date may be different from the effective date of the plan document set forth on the beginning page of this document.

**1.10 "Eligible Medical Expenses"** means those expenses incurred by a Participant or Covered Dependent that satisfy the conditions set forth in the Plan's Summary Plan Description.

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

**1.12 "Employer"** means Placer County and any Affiliated Employer who adopts the Plan pursuant to authorization provided by Placer County. Notwithstanding the previous sentence when the

Plan provides that the Employer has a certain power (e.g., the appointment of a Benefits Administrator, entering into a contract with a third-party insurer, or amendment or termination of the Plan), the term "Employer" shall mean only Placer County. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in the Plan's Summary Plan Description.

**1.13 "Health Reimbursement Account"** means the funding mechanism by which HRA Dollars (as defined in 1.15 herein) are allocated to each Participant to be used for reimbursement of Eligible Medical Expenses. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

**1.14 "Highly Compensated Individual"** means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

**1.15 "HRA Dollars"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Covered Dependents, if applicable, under the Plan. The amount of Employer contributions may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and non-discriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. In no event will any Employer contributions be disbursed to a Participant in the form of additional, taxable Compensation.

**1.16 "Participant"** means an Employee who becomes a Participant pursuant to Article II.

**1.17 "Plan"** means this Placer County Tahoe Area Health Reimbursement Arrangement.

**1.18 "Plan Administrator"** means the person(s) or Committee identified in the Plan's Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

**1.19 "Plan Year"** shall be the period of coverage set forth in the Summary Plan Description.

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

**1.21 "Summary Plan Description" or "SPD"** means the Placer County Tahoe Area Health Reimbursement Arrangement SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Appendix I, as amended from time to time. The SPD and appendices are incorporated hereto by reference.

## **ARTICLE II ELIGIBILITY AND PARTICIPATION**

**2.01 Eligibility to Participate.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of the effective date of coverage set forth in the SPD or enrollment materials. As set forth in the SPD and enrollment materials, enrollment in a Component Medical Plan will be a pre-requisite to eligibility under this Plan.

**2.02 Termination of Participation.** Participation shall terminate as of the date set forth in the SPD or enrollment materials.

**2.03 Qualifying Leave Under FMLA and USERRA.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family Medical Leave Act of 1993 (the "FMLA"), or a military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Participant will be entitled to continue coverage under this HRA on the same terms and conditions as if the Participant were still an active Employee to the extent set forth in FMLA or USERRA (for military leaves of absence, such protection will only apply for the leave period up to 30 days). The requirements for continuing coverage will be set forth in the SPD or enrollment materials.

**2.04 Non-FMLA Leave.** If a Participant goes on an unpaid leave of absence, coverage will be continued in accordance with the terms of the SPD or enrollment materials.

### **ARTICLE III BENEFITS**

**3.01 Source of Benefits.** All benefits provided under this HRA shall be funded with HRA Dollars. No benefits provided under this HRA shall be funded, directly or indirectly, with any employee contributions (including pre-tax salary reductions under a Code Section 125 Cafeteria Plan) except as otherwise required for Continuation Coverage set forth in Article IX.

**3.02 Reduction of Coverage to Prevent Discrimination.** If the Plan Administrator (or its designee) determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code, the Plan Administrator shall take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of such Highly Compensated Individual's coverage under this HRA without the consent of such Employee.

**3.03 Health Care Reimbursement.** Each Participant's Health Reimbursement Account will be credited with HRA Dollars for reimbursement of Eligible Medical Expenses in accordance with the terms of the SPD. The Health Reimbursement Account will be debited for reimbursements of Eligible Medical Expenses disbursed to the Participant in accordance with the SPD or enrollment materials and Sections 4.10 and 4.11 herein. The Employer may credit such Health Reimbursement Account with the entire annual HRA Dollar amount as of the effective date of coverage for such Plan Year or the Employer may credit the Health Reimbursement Account with HRA Dollars on a pro-rata basis throughout the Plan Year. The manner in which HRA Dollars are credited to the Participant's Health Reimbursement Account will be described in the SPD or enrollment materials. The maximum amount of Reimbursement at any particular time during the Plan Year shall not exceed the amount credited to the Health Reimbursement Account. Any amount credited to the Health Reimbursement Account that is not applied towards Eligible Medical Expenses prior to the end of the Plan Year may remain in the Health Reimbursement Account for use in the next Plan Year to the extent set forth in the SPD or enrollment materials. Any amounts that are not permitted to remain in the Health Reimbursement Account in accordance with the SPD or enrollment materials shall be forfeited and returned to the Employer. The maximum reimbursement under this HRA shall be set forth in the SPD or enrollment materials.

**3.04 Repayment of Excess Reimbursements.** If it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.10 herein (for any reason), the Plan Administrator (or its designee) shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within the time frame established by the Plan Administrator. If repayment is not made, the Plan Administrator (or its designee) shall direct the Employer to withhold such excess reimbursement from the Participant's compensation as taxable income. If that is not successful, the Plan Administrator (or its designee) may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement, as set forth in the preceding sentences of this Section 3.04, are unsuccessful, the

Plan Administrator (or its designee) may direct the Employer to include such amounts in the gross income of the Employee.

**3.05 Termination of Health Reimbursement Account.** Coverage under the HRA shall cease in accordance with Section 2.02. However, Participants may submit claims for reimbursement for Eligible Medical Expenses arising before the termination date in accordance with Section 4.10 herein and the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after coverage ceases under this Plan. Any unused HRA Dollars credited to the Health Reimbursement Account in accordance with Section 3.03 herein will be forfeited and returned to the Employer.

**3.06 Coordination of Benefits Under the HRA.** The HRA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan. In addition, Eligible Medical Expenses that are potentially eligible for reimbursement under this HRA and also a Health Flexible Spending Arrangement (as defined in Treas. Reg. 1.125-2, Q-7) sponsored by the Employer will be processed in accordance with the terms of the SPD or enrollment materials.

#### **ARTICLE IV PLAN ADMINISTRATION**

**4.01 Allocation of Authority.** The Board of Supervisors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- (a) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;
- (b) To make and enforce such rules and regulations and prescribe the use of such forms as it shall deem necessary for the efficient administration of the Plan;
- (c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;
- (d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer and insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;
- (e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a Benefits Administrator and shall be identified in the SPD;
- (f) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan; and

- (g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

**4.02 Provision for Benefits Administrators.** The Plan Administrator, subject to approval of the Employer, may employ the services of the Benefits Administrator (or such persons, as it may deem necessary or desirable in connection with the operation of the Plan) and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the SPD as a Benefits Administrator. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

**4.03 Fiduciary Liability.** To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for acts or failures to act involving the Plan Administrator's own gross negligence, willful neglect, willful misconduct or willful breach of this Plan.

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

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

**4.06 Payment of Administrative Expenses.** The Employer has discretion to pay the administrative expenses arising from the Plan or to pass the expenses on to the Participants of the Plan.

**4.07 Funding Policy.** The Employer shall have the sole discretion to determine the manner in which benefits under the Plan are paid. The Employer may pay benefits from a trust (taxable or non-taxable) established in accordance with applicable law. The Employer may pay benefits solely as needed from the Employer's general assets and/or the Employer may enter into one or more contracts with one or more insurance companies for the purpose of providing benefits under the Plan. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

- (a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;
- (b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure;
- (c) The Employer will not be liable for the payment of any insurance premium or any loss that may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this Plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

- (d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

**4.08 Disbursement Reports.** The Plan Administrator (or its designee) shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

**4.09 Indemnification.** The Plan Administrator and Benefits Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

**4.10 Substantiation of Expenses.** Each Participant must submit a written Claim Form to the Benefits Administrator identified in the SPD or enrollment materials to receive reimbursements from the HRA, on a form provided by the Plan Administrator, accompanied by a written statement/ bill from an independent third party stating that the expense has been incurred, and the amount thereof. The Claim Form shall contain such evidence, as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed. All Claim Forms must be submitted on or before the end of the Run Out Period described in the SPD or enrollment materials.

**4.11 Reimbursement.** Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator.

**4.12 Statements.** The Plan Administrator or its designated Benefits Administrator may periodically furnish each Participant with a statement showing such information as it deems reasonable and appropriate (e.g., the amounts paid or expenses incurred by the Employer in providing reimbursement under this Plan and the respective Health Reimbursement Account balance).

**4.13 Integration with Component Medical Plan.** Although established pursuant to separate documents, this Plan and the Component Medical Plan(s) identified in the SPD or enrollment materials should be considered a single plan for all purposes. Notwithstanding the previous sentence, nothing in this document (including the SPD or enrollment materials incorporated hereto by reference) should be construed to provide benefits under the Component Medical Plan(s) other than as set forth in the governing documents for the Component Medical Plan(s). In addition, nothing in this document shall modify, supercede, or revise the terms set forth in the governing documents of the Component Medical Plan(s) as they relate to the Component Medical Plan(s).

## **ARTICLE V CLAIMS PROCEDURES**

The Plan has established procedures for full and fair review of claims denied under this Plan and those claims review procedures are set forth in the SPD and the enrollment materials.

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

**6.01 Permanency.** While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 6.02 and 6.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

**6.02 Employer's Right to Amend.** The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g., by approval by the Board of Supervisors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer that participates in this Plan.

**6.03 Employer's Right to Terminate.** The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan but may not terminate the Plan.

**6.04 Determination of Effective Date of Amendment or Termination.** Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Health Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided herein.

## **ARTICLE VII GENERAL PROVISIONS**

**7.01 Not an Employment Contract.** Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

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

**7.03 Post-Mortem Payments.** Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse; otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator (or its designee) may retain such amount until the rights thereto are determined, without liability for any interest thereon.

**7.04 Non-Alienation of Benefits.** Except as expressly provided by the Plan Administrator (or its designee), no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

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

**7.06 Inability to Locate Payee.** If the Plan Administrator (or its designee) is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

**7.07 Requirement for Proper Forms.** All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required by the Plan Administrator.

**7.08 Source of Payments.** The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. If a trust is used to fund benefits, the trust assets shall serve as a source of Plan benefits. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

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

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

**7.11 Gender and Number.** Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

**7.12 Headings.** The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

**7.13 Incorporation by Reference.** The actual terms and conditions of the separate component Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. In addition, the SPD for this Plan contains many of the actual terms and conditions of this Plan. To that end, the SPD, as amended from time to time, is incorporated herein.

**7.14 Severability.** Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

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

**7.16 Forfeiture of Unclaimed Health Reimbursement Account Benefits.** Except to the extent contrary to state law, any Health Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the claims payment date set forth in the SPD or enrollment materials shall be forfeited. If benefits are funded by the Employer using notional bookkeeping accounts, the

forfeited benefits shall belong to the Employer. If a trust is used to fund benefits hereunder, any forfeited benefits shall be used solely to offset Plan expenses or fund future Plan benefits for Participants.

**ARTICLE VIII  
HIPAA PRIVACY AND SECURITY**

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

**8.02 Effective Date.** This Article VIII is effective on April 14, 2003 (or such later effective date of the Privacy Rules with respect to the Plan).

**8.03 Use and Disclosure of PHI.**

- (a) **General.** The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.
- (b) **Disclosure to the Employer.** The Plan will disclose PHI to the Employer, or where applicable, an Affiliate only upon receipt of written certification from the Employer that:
  - (i) The Plan Document has been amended to incorporate the provisions in this Article VIII; and
  - (ii) The Employer agrees to implement the provisions in Section 8.04 herein.

**8.04 Conditions Imposed on Employer.** Notwithstanding any provision of the Plan to the contrary, the Employer agrees:

- (a) Not to use or disclose PHI other than as permitted or required by this Article VIII or as required by law;
- (b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;
- (c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;
- (d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;
- (e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIII, if it becomes aware of an inconsistent use or disclosure;
- (f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;
- (g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

- (h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (i) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;
- (j) If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;
- (k) To ensure adequate separation between the Plan and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article VIII; and
- (l) To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (other than enrollment/ disenrollment information) and it will ensure that any agents or subcontractors to whom it provides such electronic PHI agrees to implement reasonable and appropriate safeguards to protect the information.

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

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

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

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

**8.09 Privacy and Security Official.** The Plan shall designate a Privacy and a Security Official, who will be responsible for the Plan's compliance with HIPAA's Privacy and Security Rules including, but not limited to those duties described below. The Privacy Official and the Security Official may be the same individual. The Privacy and Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy and Security Official deems necessary or advisable:

- (a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article VIII
- (b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;
- (c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;

- (d) Establishing and overseeing proper training of the Plan, or Employer personnel who will have access to Protected Health Information;
- (e) Any other duty or responsibility that the Privacy and Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article VIII.

**8.10 Non-Compliance.** The Employer shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIII.

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

**"Individual"** means the person who is the subject of the health information created, received or maintained by the Plan or Employer.

**"Organized Health Care Arrangement"** means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.

**"Privacy Notice"** means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

**"Privacy Rules"** means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

**"Protected Health Information or PHI"** means individually identifiable health information as defined in 45 C.F.R. § 160.103.

**8.12 Interpretation and Limited Applicability.** This Article VIII serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article VIII nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIII are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

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

**ARTICLE IX  
CONTINUATION COVERAGE UNDER COBRA**

The SPD and enrollment materials include continuation of coverage provisions under COBRA that shall apply to the HRA to the extent the Employer is subject to COBRA as set forth in the relevant Code, statutory provisions and the applicable regulations promulgated thereunder.

**IN WITNESS WHEREOF**, the Employer has executed this HRA as of the date set forth below.

**PLACER COUNTY**

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

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

Date: \_\_\_\_\_

**APPENDIX I**

**SUMMARY PLAN DESCRIPTION  
TO THE  
PLACER COUNTY**

*Amended and Restated*  
**TAHOE AREA  
HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")**

Original Effective Date: January 1, 2001

**The effective date of this document is January 1, 2008.**

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## INTRODUCTION

**PLACER COUNTY** (the "Employer") has established this **TAHOE AREA HEALTH REIMBURSEMENT ARRANGEMENT** (the "HRA") for:

- the employees of the Placer County Deputy Sheriffs Association (PCDSA), and
- the employees of the Placer Public Employees Organization, (PPEO), and
- the employees of the Management & Confidential Team,

whose position assignments are in the Tahoe area.

The purpose of this HRA is to reimburse Participants (see Q-2 for more information on how to become a Participant) for certain unreimbursed medical expenses ("Eligible Medical Expenses") incurred by the Participant or his/her Covered Dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code ("Code").

This Summary Plan Description or "SPD" describes the basic features of the HRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. Attached to this SPD is a Plan Information Appendix that provides important information specifically related to this HRA (e.g., the name of the sponsoring Employer and Plan Administrator, the plan number, and the maximum level of reimbursement available under this particular HRA). If you do not have a Plan Information Appendix for this SPD, you should contact the Employer. The Plan Information Appendix may be replaced from time to time to reflect changes made to the HRA. You should check your Plan Information Appendix to ensure that you have the most recent Plan Information Appendix. You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated. Other Appendices may be attached to this SPD to the extent referenced in this SPD. The Plan Information Appendix and any other appendices referenced in this SPD should be considered a part of the SPD (i.e., the SPD, the Plan Information Appendix and any other applicable appendices together constitute the entire SPD).

This HRA has been established and is operated in accordance with both this SPD and the official plan document. This SPD (including the applicable Appendices) has been incorporated into and made a part of the official plan document (i.e., the official plan document and this SPD together constitute the plan document for this HRA). Although the SPD has been incorporated into and made a part of the plan document, the terms of the official plan document will control if there is a conflict between this SPD and the official plan document.

This HRA is considered a component of the Employer's medical plan(s) ("Component Medical Plan") specifically identified in the Plan Information Appendix. Both the HRA and the Component Medical Plan should be considered a single employee benefit plan (or part of the same Employee benefit plan) even though they are described in separate documents. The governing documents for this HRA are not intended to replace, supersede, modify or revise the governing documents of the Component Medical Plan. For purposes of this SPD, the Component Medical Plan and this HRA are collectively referred to as the "Plan."

## GENERAL INFORMATION ABOUT THE PLAN\*

*\*You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document into which this SPD is incorporated.*

### **Q-1. What is the HRA?**

Generally, the HRA is an Employer-provided medical expense reimbursement account. The HRA works as follows:

- The Employer establishes a notional account called a Health Reimbursement Account ("Reimbursement Account") for each Participant (see Q-2 for more information on how to become a Participant).
- Each Plan Year, the Employer allocates a specified amount of Employer contributions, called "HRA Dollars," to each Participant's Reimbursement Account for reimbursement of Eligible Medical Expenses. You generally do not contribute to the Reimbursement Account.

More information on the Reimbursement Account, HRA Dollars allocated to the Account, and forfeiture of HRA Dollars is provided below.

### **Q-2. Who is eligible for this HRA?**

You are eligible to participate in this HRA if you work a minimum of 20 hours per week, or 40 hours per pay period, and are permanent employees of the:

- Placer County Deputy Sheriffs Association (PCDSA), or
- Placer Public Employees Organization, (PPEO), or
- Management & Confidential Team,

whose position assignments are in the Tahoe area.

Individuals who are considered to be "self-employed" under the Internal Revenue Code (e.g., more than 2% shareholder of an S Corporation, member of an LLC) are not eligible for this HRA. Eligible employees who become covered under this HRA are called "Participants."

### **Q-3. Are my Dependents covered under this HRA?**

If you become a Participant, you may also be reimbursed for Eligible Medical Expenses incurred by your Covered Dependents. A "Covered Dependent" for purposes of this HRA is any individual who meets both of the following conditions: (i) the individual is covered as a spouse or "dependent" under the Component Medical Plan(s) and (ii) the individual is a legal "spouse" (as determined in accordance with state law to the extent consistent with federal law) or a "dependent" as defined in Code Section 105(b).

In addition, this HRA will cover a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this HRA. The Plan Administrator of the Component Health Plan(s) (or its designee) will notify you if a QMCSO has been received. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The Plan Administrator will notify both you and the affected

child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting either the Plan Administrator of the Component Health Plan(s) or the Plan Administrator of this HRA (as identified in the Plan Information Appendix).

**Q-4 How do I enroll in this HRA?**

Generally, your enrollment in this HRA is automatic if you have enrolled in a Placer County Component Medical Plan and your position assignment is in the Tahoe area. You may be permitted to enroll in the Component Medical Plan during the Component Medical Plan's initial enrollment period, the annual enrollment period, or during the Plan Year to the extent permitted by the Component Medical Plan (e.g., during a special enrollment period). The Component Medical Plan must allow you to enroll yourself, if you are otherwise eligible, if you declined coverage under the Component Medical Plan for yourself or your eligible dependents when first eligible because you or your dependents had coverage under another group health plan and that other group coverage has been lost for reasons other than failure to pay premiums or cause. You must request enrollment within at least 30 days of losing the other coverage in order to be eligible for this special enrollment (although the Plan's special enrollment period may be longer than 30 days). Coverage must be effective no later than the first day of the month following the date you request for enrollment (but it may be earlier).

In addition, the Component Medical Plan must allow you to enroll yourself if you are otherwise eligible if you request enrollment within at least 30 days of gaining a new dependent through marriage, birth, adoption or placement for adoption. In the case of coverage resulting from a newborn or adopted child, coverage is effective as of the date of the birth. In the case of coverage resulting from gaining a new dependent through marriage, coverage must be effective no later than the first day of the month following the date you request enrollment (but it may be earlier).

**Q-5. How do I enroll my Eligible Dependents in this HRA?**

You may be able to enroll your eligible dependents in the Component Medical Plan when you enroll in the Component Medical Plan during annual enrollment or during the Plan Year to the extent permitted by the Component Medical Plan. The Component Medical Plan must allow you to enroll your otherwise eligible dependents (and yourself) if you declined coverage under the Component Medical Plan for your eligible dependents when first eligible because your dependents had coverage under another group health plan and that other group coverage is lost for reasons other than failure to pay premiums or cause. You must request enrollment within at least 30 days of your dependents losing the other coverage (although the Plan's special enrollment period may be longer than 30 days). Coverage must be effective no later than the first day of the month following the date your enrollment is received by the Plan Administrator (but it may be earlier).

In addition, the Component Medical Plan must allow you to enroll a new dependent (and yourself) if you request enrollment within at least 30 days from the date that you gain the new dependent through marriage, birth, adoption or placement for adoption. In the case of coverage for a newborn or adopted child, coverage is effective as of the date of the birth. In the case of coverage for a new dependent gained through marriage coverage must be effective no later than the first day of the month following the date your enrollment is received by the Plan Administrator (but it may be earlier).

**Q-6. What is the effective date of coverage under this HRA?**

Coverage under this HRA for an Eligible Employee and Eligible Dependent(s) begins on the applicable date identified in the "Effective Date of Coverage" section of the Plan Information Appendix. In no event will the coverage under this HRA begin before the earlier of the effective date of this HRA or the effective date of coverage under this HRA. The effective date of this HRA is identified in the Plan Information Appendix.

**Q-7. When does coverage under this HRA end?**

Coverage for a Participant and/or Covered Dependent ends on the same date that coverage under the Component Medical Plan ends.

However, you, your covered spouse, and/or your covered child(ren) may be eligible to continue coverage under this HRA and the Component Medical Plan (if applicable) in accordance with federal law beyond the date that coverage would otherwise end if coverage is lost for certain reasons. Your continuation of coverage rights and responsibilities are described below and in the Component Medical Plan SPD. All HRA dollars allocated to your Reimbursement that are not applied towards Eligible Medical Expenses incurred before your coverage termination date in accordance with Q-15 of this SPD are forfeited.

**Q-8. What happens to my HRA coverage if I take a leave of absence from my Employer during the Plan Year?**

Your coverage under this HRA during a paid or unpaid leave of absence will be treated in the same manner that coverage under the Component Medical Plan is treated during a leave of absence. For a detailed summary of the continuation rights under the Component Medical Plan during a leave of absence, please refer to the governing documents of the Component Medical Plan and/or your Employee Handbook.

As described in this SPD, the HRA will pay you up to the maximum amount in your Reimbursement Account and your Reimbursement Account will not be prorated, unless otherwise required by law. Services must be received during your employment with Placer County.

**Q-9. What is an "Eligible Medical Expense"?**

"Eligible Medical Expenses" are medical care expenses *incurred* by you or your Covered Dependents that satisfy all of the conditions described in the "Eligible Medical Expense" section of the Plan Information Appendix and are for "medical care" as defined in Code Section 213(d). All expenses that are not specifically within the scope of "Eligible Medical Expenses" described in the Plan Information Appendix are implicitly excluded. "Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an otherwise Eligible Medical Expense will not be reimbursed unless the substantiation requirements described below have been satisfied.

In no event will the following expenses be eligible for reimbursement:

- a) any expense that is not a Code Section 213(d) expense
- b) any expenses incurred for qualified long term care services (as defined in Code Section 106)
- c) expenses incurred *prior to the date* that coverage under this HRA becomes effective

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- d) expenses incurred *after the date* that coverage under this HRA ends
- e) expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Whether an Expense is an "Eligible Medical Expense" is within the sole discretion of the Plan Administrator.

**Q-10. What is a HRA Reimbursement Account?**

Once you become a Participant, the Employer establishes a Reimbursement Account for you. The Reimbursement Account is a notional bookkeeping account that keeps a record of HRA Dollars allocated to your account and reimbursements made to you under this HRA (except as otherwise noted in the Plan Information Appendix). You have no property rights in the Reimbursement Account.

**Q-11. Who contributes to my Reimbursement Account?**

While you are an active employee, the Employer allocates HRA Dollars to your Reimbursement Account. You do not contribute to the Reimbursement Account (except during a COBRA continuation coverage period). In fact, federal laws prohibit you from contributing to your Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the "applicable premium" for continuation of HRA coverage under COBRA (please see below for more information regarding COBRA continuation coverage).

**Q-12. How are HRA dollars allocated to my Reimbursement Account?**

Each Plan Year, the Employer allocates a specified amount of HRA Dollars to your Reimbursement Account. The maximum annual HRA Dollar amount is identified in the "HRA Dollar" section of the Plan Information Appendix. The amount of HRA Dollars allocated to your Reimbursement Account is determined in the sole discretion of the Employer and may vary depending on circumstances such as family status. Nevertheless, the annual amount of HRA Dollars allocated to each Participant's Reimbursement Account will be determined in a uniform and non-discriminatory manner in comparison to other similarly-situated employees.

In addition, HRA Dollars will be allocated to your Reimbursement Account in accordance with the "HRA Dollar" section of the Plan Information Appendix. For example, the Employer may allocate the full annual amount to your Reimbursement Account on the first day of coverage during the Plan Year or the Employer may periodically allocate a pro-rata portion of the annual amount to your Account (e.g., monthly, quarterly, etc.).

**Q-13. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?**

Although HRA Dollars allocated to your Reimbursement Account in accordance with Q-10 of this SPD may remain in your Reimbursement Account for future reimbursement of Eligible Medical Expenses incurred during your period of coverage during your employment with the Employer, carry over of funds is not permitted under this Plan.

**Q-14. Is there a limit on how much can be allocated to my Reimbursement Account?**

The amount in your Reimbursement Account can never exceed the Reimbursement Account Maximum identified in the "Reimbursement Account" section of the Plan Information Appendix (if

any). Any HRA Dollars that you would otherwise be entitled to under the terms of this HRA will be forfeited to the extent your Reimbursement Account has reached its Reimbursement Account Maximum. If your Reimbursement Account has reached the Reimbursement Account Maximum, your Reimbursement Account will be temporarily closed until such time as your Reimbursement Account balance is less than the maximum. At such time you will be entitled to receive your allocable share of HRA Dollars, not to exceed the Reimbursement Account Maximum, at the next regularly scheduled allocation. For example, if HRA Dollars are allocated monthly and your Reimbursement Account balance goes below the Reimbursement Account Maximum in June, you will be entitled to receive an HRA Allocation in July up to the Reimbursement Account maximum. If HRA Dollars are allocated each January 1, and your Reimbursement Account balance goes below the Reimbursement Account maximum in July, you will receive an HRA Dollar allocation the following January 1 up to the Reimbursement Account maximum.

**Q-15. What is the maximum amount of reimbursement that I may receive under this HRA during the Plan Year?**

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be suspended and processed when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any subsequently filed claims are paid.

**Q-16. Can I change my level of coverage under this HRA during the Plan Year?**

If you change your level of coverage under the Component Medical Plan during the Plan Year (e.g., single to family, family to single, part-time to full-time, or full-time to part-time) and there is a different HRA Dollar allocation associated with the new level of coverage, your annual HRA Dollar allocation may be adjusted to the extent described in the "Changing Coverage" section of the Plan Information Appendix. All adjustments (if any) will be applied prospectively only.

**Q-17. How do I receive reimbursement under this HRA?**

You may request a blank form from the Plan's Benefits Administrator.

Claims for Eligible Medical Expenses cannot be submitted to the HRA until the amount totals \$50.00 or more, unless the balance remaining in the HRA at the end of the Plan Year or a Participant's period of coverage during the Plan Year is less than \$50.00.

If available in the normal course of business, you must include with your Request for Reimbursement Form a copy of the Explanation of Benefits ("EOB") document(s) showing "Your Responsibility to Pay."

You may be required to provide additional supporting documentation for substantiation to the extent determined necessary to support your claim. The Benefits Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense," you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

If your Employer offers the Electronic Payment Card under this HRA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see

"Traditional Paper Claims" below for more information). Alternatively, if applicable, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay for the eligible expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

**Traditional Paper Claims:** When you incur an Eligible Medical Expense, you file a claim with the Plan's Benefits Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Benefits Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service.

The Benefits Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run Out Period is described in the Plan Information Summary.

**Electronic Payment Card:** If your Employer offers this option, the Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must generally make an election to use the card (see your enrollment materials for the applicable Plan Year).* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan ends. The enrollment materials for the applicable Plan Year will specify whether the card may be used during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your HRA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *HRA reimbursement under the card is limited to health care providers (including pharmacies) and IIAS certified merchants.* Use of the card for HRA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.) or have established an *IRS-approved IIAS system pursuant to IRS Notice 2006-69 and any subsequent guidance.* As set forth in the Cardholder Agreement, you will not be able to use the card at certain retail stores.

(e) *You use the card at the health care provider or IIAS-certified merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office, such as a co-payment, you use the card at the provider's office much like you would a typical credit or debit card. You present the card to the pharmacist of participating pharmacies like you do a prescription drug card. The card pays your eligible prescription drug expenses not covered by insurance or your drug plan. The provider is paid for the expense up to the maximum reimbursement amount available under the HRA (or as otherwise limited by the Program) at the time that you use the card. Every time you use the card, you certify to the Plan that the expense for which payment under the HRA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

(f) *You must obtain and retain a receipt/ third-party statement each time you use the card.* Each time you use the card, a written statement (e.g., a receipt, EOB, etc.) from the health care provider and/or IIAS-certified merchant, associated with each Eligible Medical Expense, must indicate the following:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The date the expense was incurred.
- The amount of the expense.
- The provider's name
- The patient's name.

NOTE: If available in the normal course of business, you must submit an Explanation of Benefits (EOB) for your third-party statement with your claim.

You must retain your written statements/ receipts for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the card arrangement, a written third-party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a notification from the Benefits Administrator if a third-party statement is needed. You must provide the third-party statement to the Benefits Administrator within 7 days (or such longer period provided in the notification from the Benefits Administrator) of the request.

(g) *There are situations where the third-party statement will not be required to be provided to the Benefits Administrator.* There may be situations in which you will not be required to provide the written statement to the Benefits Administrator. More detail as to which situations apply under your Plan can be obtained by contacting the Plan Administrator or Benefits Administrator:

- **Co-Pay Match:** Written statements may not be necessary if the Electronic Payment Card payment matches a specific co-payment you have under the Component Medical Plan for the particular service that was provided. For example, if you have a \$10 co-pay for physician office visits, and the payment was made to a physician office in the amount of \$10, you may not be required to provide the third-party statement to the Benefits Administrator.
- **Previously Approved Claim Match:** Written statements may not be required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the Benefits Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is used for subsequent

refills at ABC Pharmacy the receipt may not need to be provided to the Benefits Administrator if the expense incurred is the same amount.

- **Provider Match Program:** Third-party statements may not be required to be submitted to the Benefits Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider or IAS-certified merchant that identifies the nature of your expense and verifies the amount.

*Note: You should still obtain the third-party receipt when you incur the expense and use the card, even if you think it will not be needed, so that you will have it in the event the Benefits Administrator does request it.*

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Benefits Administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, your usage of the card may be terminated by the Employer.

(i) The Benefits Administrator may offset any improperly paid claims by substituting other paper claims or by withholding a portion of the total reimbursement payment of a paper claim until the outstanding transaction is paid in full.

(j) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

#### **Q-18. What happens if my claim for reimbursement is denied?**

If you are denied claim for reimbursement under this Plan, you should proceed in accordance with the following claims review procedures.

**Step 1: Notice is received from Benefits Administrator.** If your claim is denied, you will receive written notice from the Benefits Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Benefits Administrator, the Benefits Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Benefits Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2: Review your notice carefully.** Once you have received your notice from the Benefits Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

**Step 3: If you disagree with the decision, file an appeal.** If you do not agree with the decision of the Benefits Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1.

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You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

**Step 4:** *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Benefits Administrator.

**Step 5:** *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Benefits Administrator.

**Step 6:** *If you still disagree with the Benefits Administrator's decision, file a 2<sup>nd</sup> Level Appeal with the Plan Administrator.* If you still do not agree with the Benefits Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2<sup>nd</sup> Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

### **Important Information**

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures.
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their HRA Reimbursement Account.

### **Q-19. What happens if I receive overpayments or reimbursements from this HRA are made in error?**

If it is later determined that you and/or your Covered Dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the HRA that is later paid for by the Component Medical Plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which has tax implications for you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA (and to the extent permissible, under the Component Medical Plan).

### **Q-20. What is "Continuation Coverage" and how does it work?**

A federal law called "COBRA" requires most Employers sponsoring group health plans to offer covered Employees and certain covered family members the opportunity for a temporary extension of health care

coverage (called "Continuation Coverage") in certain instances where coverage under the group health plan would otherwise end. These rules apply to coverage under the Component Medical Plan and the HRA unless the Employer is a small Employer as defined under applicable law (generally less than 20 employees during the preceding year). The Plan Administrator (or its designee) will inform you whether the Plan is subject to these rules. Below is a description of your rights and responsibilities under the federal COBRA rules and regulations.

#### Who May Continue Coverage Under COBRA?

Since this HRA and the Component Medical Plan are considered a single Plan, you cannot continue coverage under this HRA unless you elect coverage under the Component Medical Plan. Nevertheless we have generally described your rights to continue coverage under the Plan pursuant to federal COBRA. You should also refer to the governing documents for the Component Medical Plan for additional continuation of coverage information.

Federal COBRA requires group health plans to provide "Qualified Beneficiaries" an opportunity to temporarily continue group health coverage when that coverage is lost (or should be lost) as a result of certain "Qualifying Events." A "Qualified Beneficiary" is the employee, Spouse, or Dependent Child covered under the Plan immediately preceding the Qualifying Event. A child born to or adopted by (including a child placed for adoption with) a covered employee during the covered employee's COBRA period is also considered a "Qualified Beneficiary" if properly enrolled.

#### When May Coverage Be Continued Under COBRA?

Coverage may only be continued if coverage is lost as a result of certain "Qualifying Events."

You have the right to COBRA continuation coverage if you lose coverage under the Plan as a result of a termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment.

Your spouse has the right to COBRA continuation coverage under the Plan if your spouse loses coverage under the Plan as a result of any one of the following four events:

- you terminate employment (for reasons other than gross misconduct) or have a reduction in your hours of employment (including a military leave of absence)
- you die
- you and your spouse divorce or legally separate
- you become entitled to Medicare.

Your covered dependent children may have the right to COBRA continuation coverage under the Plan if your dependent children lose coverage as a result of any one of the following five events:

- you terminate employment or have a reduction in your hours of employment
- you die
- you and your spouse divorce or legally separate

- you become entitled to Medicare.
- your dependent child ceases to be an eligible dependent under the Plan

A child born to or adopted by (including a child placed for adoption with) a covered employee during the covered employee's COBRA period is also considered a "Qualified Beneficiary" if properly enrolled.

#### Notice and Election Rules

The Plan Administrator must send notice to Qualified Beneficiaries of the right to the continuing participation following the covered employee's termination of employment, reduction in hours or death.

If the covered spouse and/or covered dependent children lose coverage as a result of a divorce, legal separation, or dependent child ceasing to be a dependent, you or the affected Qualified Beneficiary must send notice to the COBRA Administrator identified in the Plan Information Appendix within 60 days of the later of:

- the Qualifying Event and
- the date coverage is lost as a result of such Qualifying Event or

The Qualified Beneficiary will then be sent a notice of this right to continuing participation following receipt of Qualified Beneficiary's notice.

Once you and/or any other Qualified Beneficiary have been provided notice of the right to elect COBRA continuation coverage, an election for continuation coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the Qualifying Event. If a Qualified Beneficiary fails to provide this notice to the COBRA Administrator identified in the Plan Information Appendix during this 60-day notice period, the Qualified Beneficiary will lose the right to COBRA continuation coverage and coverage under the Plan will cease as of the last date you were eligible for coverage. Each Qualified Beneficiary has a separate and independent right to elect COBRA continuation coverage. A Qualified Beneficiary employee or spouse can elect coverage for any other Qualified Beneficiary. On the other hand, you may not decline COBRA continuation coverage for the Qualified Beneficiary spouse. A parent or guardian can elect coverage for a Qualified Beneficiary child who is a minor.

#### Duration of Coverage

Qualified Beneficiaries may continue coverage for 18 months if coverage is lost as a result of your termination of employment (for reasons other than gross misconduct) or coverage ends because of your reduction in hours of employment. Qualified Beneficiaries other than the covered employee may continue coverage under the Plan for 36 months if coverage is lost as a result of the covered employee's death, a divorce or legal separation or a dependent child ceasing to be a dependent, or you become entitled to Medicare.

If you or a Qualified Beneficiary family member is determined by the Social Security Administration to have been disabled at any time prior to the end of the first 60 days of continuation coverage resulting from a termination or reduction in hours of employment, COBRA may be extended from 18 months up to 29 months. You or a Qualified Beneficiary must notify the Plan Administrator prior to the end of the end of the

original COBRA period (up to 18 months) or the 60-day notice period, whichever comes first. The 60 day notice period ends 60 days after the latter of:

- The date of the Social Security Administration's determination
- The date of the Qualifying Event (i.e. termination of employment)
- The date that coverage is lost as a result of the Qualifying Event.

If the Social Security Administration determines that you or a Qualified Beneficiary is no longer disabled while on COBRA continuation coverage, you or a Qualified Beneficiary must notify the Plan Administrator within 30 days of the date the Social Security Administration's determination that you are no longer disabled.

If you become entitled to Medicare and then subsequently lose coverage, terminate employment or have a reduction in hours of employment, within 18 months of your Medicare entitlement, your Qualified Beneficiary spouse and/or covered children are eligible to receive 36 months of continuation coverage beginning on the Medicare entitlement date.

If COBRA coverage was elected following a termination of employment or reduction in hours of employment, additional Qualifying Events (such as divorce, Medicare entitlement, or death) may occur during the first 18 months (or during the disability extension discussed above) that may result in an extension of the 18-month (or 29 month) continuation period to 36 months for the Qualified Beneficiary Spouse and/or child. In no event will COBRA continuation coverage last longer than 36 months from the date of the termination of employment or reduction in hours of employment. You or your Qualified Beneficiary must notify the COBRA Administrator within 60 days of the event if a second Qualifying Event occurs during your continuation coverage period. NOTE: A second event will not entitle your Qualified Beneficiary Spouse to additional coverage unless the event would have caused a loss of coverage if it was the initial Qualifying Event.

In all situations in which you or another Qualified Beneficiary is required to provide notice of a Qualifying Event (either an initial Qualifying Event or a subsequent Qualifying Event), you must identify the Qualifying Event, the date of the Qualifying Event, and the Qualified Beneficiaries impacted by the Qualifying Event.

#### Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for you immediately preceding the Qualifying Event. If applicable, at the beginning of each Plan Year that COBRA is in effect under this HRA, you will be entitled to an increase in your Reimbursement Account Balance equal to the sum of the HRA Dollars allocated to similarly-situated active Participants (subject to any restrictions applicable to similarly-situated active Participants) so long as you continue to pay the applicable premium.

#### Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102% of the "applicable premium", as determined by the Plan Administrator, or 150% of the "applicable premium" during any disability extension to which you may be entitled, as determined by the Social Security Administration. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (e.g., who you pay the premium to, etc.).

### Early Termination of Coverage

Your continuation coverage will end prior to the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- The Employer no longer provides group health coverage to any of its employees.
- The Qualified Beneficiary does not make the required payments (within the grace period).
- You or a Qualified Beneficiary on COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual (this does not apply during the 1<sup>st</sup> 18 months of continuation coverage due to a military leave of absence).
- You or a Qualified Beneficiary on COBRA becomes entitled to Medicare after the date COBRA is elected.
- Coverage has been extended for up to 29 months due to Qualified Beneficiary's disability and there has been a final determination that the Qualified Beneficiary is no longer disabled on the 29 month period is exhausted. Coverage will end the first day of the month that begins more than 30 days after the determination that you are no longer disabled.

#### **Q-21. How long will this Plan remain in effect?**

Although the Employer expects to maintain this Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/ terminations effectuated by the Employer will be applied to all Participants and Covered Dependents except as otherwise stated.

#### **Q-22. Does this HRA coordinate with other medical plans (including an Employer-sponsored Health FSA)?**

This HRA coordinates with other medical plans only as provided herein. If you are also a Participant in a Health Flexible Spending Arrangement (commonly referred to as a "Health FSA") sponsored by your Employer that covers the same expenses as this HRA, the expenses covered both by the HRA and the Health FSA will be paid as described in the Plan Information Appendix.

#### **Q-23. Whom do I contact if I have questions about this HRA?**

If you have any questions about this HRA, you should contact the Benefits Administrator or the Plan Administrator. Contact information for the Benefits Administrator and the Plan Administrator is provided in the Plan Information Appendix in this SPD.

## PLAN INFORMATION APPENDIX

The effective date of this Plan Information Appendix is January 1, 2008. This Appendix provides information specific to the **Placer County Tahoe Area Health Reimbursement Arrangement ("HRA")** established for the permanent employees who work a minimum of 20 hours per week, or 40 hours per pay period, for:

- Placer County Deputy Sheriffs Association (PCDSA), and
- Placer Public Employees Organization, (PPEO), and
- Management & Confidential Team,

whose position assignments are in the Tahoe area.

NOTE: Participants whose position assignments are in the Tahoe area but who elect coverage under other health plans, or who receive Flex Credits in lieu of Placer County paid health insurance, are not eligible for this HRA.

### I. GENERAL PLAN INFORMATION

<b>1. Name, address, and telephone number of the Employer/Plan Sponsor:</b>	Placer County 145 Fulweiler Avenue Suite 200 Auburn, CA 95603 530.889.4060
<b>2. Name, address, and telephone number of the Plan Administrator:</b>  The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees or third parties.	Placer County 145 Fulweiler Avenue Suite 200 Auburn, CA 95603 530.889.4060  Attention: Nancy Nittler, Personnel Director
<b>3. Address for Service of Legal Process:</b>	Placer County's Legal Counsel Placer County 175 Fulweiler Avenue Auburn, CA 95603
<b>4. Employer's federal tax identification number:</b>	94-600527
<b>5. Plan Number:</b>	502
<b>6. Original Effective Date of the HRA:</b>	January 1, 2001
<b>7. Plan Year:</b>	January 1 through December 31

<p><b>8. Benefits Administrator.</b> The Plan Administrator has delegated certain day to day ministerial administrative duties such as claims processing to the Benefits Administrator. The Benefits Administrator processes claims and performs other administrative duties in accordance with the terms of the Plan and/or the Plan Administrator's instructions. In addition, the Benefits Administrator may rely on guidance from applicable regulatory agencies to assist it in administering the Plan in accordance with its terms.</p>	<p>Fringe Benefits Management Company (FBMC) 3101 Sessions Road Tallahassee, FL 32303 1.800.342.8017  webcustomerservice@fbmc-benefits.com  <i>For claims:</i> P.O. Box 1800 Tallahassee, FL 32303-1800</p>
<p><b>9. COBRA Administrator:</b></p>	<p>CALPERS for Health Plan COBRA Admin.  FBMC for HRA COBRA Admin.</p>
<p><b>10. Identity of Component Medical Plan(s) under which this HRA is a component.</b></p>	<p>Refer to the current Plan Year enrollment materials</p>
<p><b>11. How is the HRA funded?</b></p>	<p>Employer's General Assets</p>

**II. EFFECTIVE DATE OF COVERAGE**

- A. The effective date of coverage for Participants is January 1, unless an otherwise Eligible Employee experiences a mid-Plan Year position assignment to the Tahoe area, which effective date of coverage is then the first of the month following date of hire.
- B. The effective date of coverage for Covered Dependents is January 1.

**III. ELIGIBLE MEDICAL EXPENSES**

The following medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

- any calendar year insurance deductible under a Component Medical Plan;
- any co-insurance payment under a Component Medical Plan;
- medical expenses that exceed the reasonable and customary amounts that the Component Medical Plan insurance companies (as applicable) will pay but **only** if those medical expenses are normally covered by said Component Medical Plan;
- the balance of charges for using out-of-network providers.

Expenses **not** eligible for HRA reimbursement are:

- expenses for dental or vision expenses,
- over-the-counter drugs, medicines and items, and
- expenses incurred under another medical plan or premium payments.

NOTE: Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging

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the mother and/or newborn earlier than 48 (or 96) hours. In any case, the plan may not require a provider to obtain pre-authorization for a hospital stay in connection with childbirth not in excess of the applicable time period.

**IV. HRA DOLLARS**

Each Plan Year, the Participants who are covered by a Placer County Component Medical Plan are credited into an HRA Reimbursement Account with a maximum Employer contribution based upon their level of medical coverage as specified in the enrollment materials for the applicable Plan Year.

NOTE: Participants whose position assignments are in the Tahoe area but who elect coverage under other health plans, or who receive Flex Credits in lieu of Placer County paid health insurance, are not eligible for this HRA.

**V. REIMBURSEMENT ACCOUNT**

The amount in your Reimbursement Account may not exceed the maximum reimbursement as identified in the enrollment materials for the applicable Plan Year.

NOTE: Participant's HRA Reimbursement Account balances will not be prorated.

**VI. CARRY OVERS**

This Plan does not permit a carry over, which means that unused balances will not be carried over to the following plan year for claims payment. If a Participant has unused funds in his or her Reimbursement Account at the end of the Plan Year, the amount may continue to be spent down for expenses incurred during the Participant's period of coverage *during* the Plan Year as long as those expenses are submitted to the Benefits Administrator for payment no later than the end of the Run Out Period (March 31) of the following year. At the end of the Run-Out Period, any amounts remaining in a Participant's HRA Reimbursement Account unclaimed through Eligible Medical Expense reimbursements shall be forfeited to the Employer.

**VII. RUN OUT PERIOD**

Eligible Medical Expenses will not be reimbursed unless they are submitted for reimbursement in accordance with this SPD. Any and all Eligible Medical Expenses must be received for payment by the Benefits Administrator no later than the end of the Run Out Period (March 31) that follows the end (December 31) of the immediately preceding Plan Year. A copy of the signed claim form and supporting documentation may be faxed to the Benefits Administrator.

**VIII. CHANGING COVERAGE**

Mid-Plan Year adjustments made to health plan coverage that result in a different HRA Dollar allocation (as described in this SPD at Section IV above) to a Participant's HRA shall be adjusted prospectively, unless otherwise required by law.

**IX. PAYMENT CLAIM DATE**

Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) in accordance with the escheat rules for the State of California.

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**X. HRA INTERACTION/ COORDINATION WITH AN EMPLOYER-SPONSORED HEALTH FSA**

To the extent that Eligible Medical Expenses are covered both by this HRA and by an Employer-sponsored Health FSA in which the employee participates, the HRA is payer of **first** resort. This means that if an Eligible Employee is enrolled in both accounts, the Participant must first submit his or her Eligible Medical Expenses for payment to the Employer-sponsored HRA and then any unpaid amount may be submitted for payment under the Employer-sponsored Health FSA.