SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

September 10, 2020

Summary of Proposed Changes for the
Cafeteria Plan Document: Plan Year 2021

The section and page numbers in this document refer to the draft cafeteria plan document for 2021

Section	Policy Change	Rationale
Section B3.1 Maximum annual Health Care FSA election Page B-3	Updated annual election amount maximum under IRS guidelines to $2750.00	2021 Benefit program update
Section B3.6 Forfeiture of Unused Balances – Use or Lose Rule and Carryover Page B-4	Updated annual carryover amount maximum under IRS guidelines to $550.00	2021 Benefit program update
Section D5.2 Dollar Value of Flex Credits Page D-3	Updated Flex Credit Amounts for City and County employee bi-weekly amounts based on coverage level and plan	Operational – 2021 benefit update
Appendix E Page E-2	Updated MEA employer paid Group Term life insurance to 100,000	2021 Benefit program update due to M.O.U. compliance
Appendix E Page E-2	Updated to reflect new benefit offerings; Met Life Critical Illness, Met Life Accident Insurance and Identity Theft Protection by Allstate	2021 Benefit program update

San Francisco Health Service System
Section 125 Cafeteria Plan

Plan Year January – December 2021~~0~~

SAN FRANCISCO
HEALTH SERVICE SYSTEM

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CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

INTRODUCTION

Effective January 1, 2021, the City and County of San Francisco amends and restates the City and County of San Francisco Section 125 Cafeteria Plan ("Plan") to incorporate applicable legislative developments and certain changes in Plan features.

Authorization

This Plan was first adopted effective December 1, 1988, pursuant to ordinance adopted by the Board of Supervisors of the City and County of San Francisco, subsequently amended (Plan added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000) and, as of the date of this amendment and restatement, codified in the Administrative Code of the City and County of San Francisco at Chapter 16, Article XVII, sections 16.900 – 16.906.

Components of Plan

The Plan is a cafeteria plan under Internal Revenue Code Section 125, which allows Eligible Employees a choice between current Compensation or pre-tax salary reductions used:

a) To pay the Eligible Employee's cost of Benefit Program coverage under the Premium Conversion Benefit Component - Appendix A;

b) To fund flexible spending accounts under:

1. The Health Care Flexible Spending Account (Health Care FSA) Component – Appendix B;

2. The Child Care Dependent Care Flexible Spending Account (Dependent Care FSA) Component pursuant to Internal Revenue Code Section 129 – Appendix C; and/or

3. For certain Eligible Employees of the City and County of San Francisco, the Superior Court of California County of San Francisco and elected officials, as designated from time to time by the Superior Court of California County of San Francisco Department of Human Resources, or the San Francisco Superior Court Human Resources Department as applicable, the Flexible Credits Benefit Component of the Plan – Appendix D.

Not an ERISA Plan

This Plan is sponsored by a local governmental entity and is not subject to ERISA.

Employers Participating in this Plan

The City and County of San Francisco and other public entities affiliated with the City and County of San Francisco that offer benefits to employees permitted under Internal Revenue Code Section 125, as authorized from time to time by a properly adopted Charter amendment or

Ordinance of the Board of Supervisors of the City and County of San Francisco, are employers participating in this Plan.

The list of other public entities affiliated with the City and County of San Francisco that are Participating Employers may be modified from time to time by a properly adopted Charter amendment, or Ordinance of the Board of Supervisors of the City and County of San Francisco, without written amendment to this Plan.

As of the date of this amendment and restatement, employers, in addition to the City and County of San Francisco, participating in this Plan include but are not limited to:

City and County of San Francisco Unified School District
San Francisco Community College District
Superior Court of California County of San Francisco

Employees Participating in this Plan

Employees participating in this Plan are individuals eligible under the Health Service System Rules and/or as specified by a properly adopted Ordinance of the Board of Supervisors of the City and County of San Francisco. Most eligible employees are covered by various collective bargaining agreements.

ARTICLE I
DEFINITIONS

When used in this Plan document, the following words and phrases have the following meanings unless the context clearly indicates otherwise.

Annual Open Enrollment Election Period
"Annual Open Enrollment Election Period" means the annual period as determined by the Plan Administrator in its sole discretion during which Eligible Employees elect Salary Reduction amounts and benefit allocations thereof for the following Plan Year. The Annual Open Enrollment Election Period for the Plan and each Benefit Component will be held before the Period of Coverage for which new elections are effective.

Benefit
"Benefit" means any of the Benefit Program options available to a Participant as outlined in Section 6.1.

Benefit Component
The "Benefit Components" are:

(a) Premium Conversion Benefit Component (Appendix A):
(b) Health Care Flexible Spending Account Benefit Component (Appendix B);
(c) Dependent Care Flexible Spending Account Benefit Component (Appendix C); and
(d) Flexible Credits Benefit Component (Appendix D)

Benefit Program
"Benefit Program" means any of the optional benefit choices available to a Participant offered through this Plan under the Health Service System Benefit Programs.

Benefit Program Premium
"Benefit Program Premium" means the amount an Eligible Employee is required to pay as a condition of coverage under the Benefit Program(s) in which Eligible Employees and Eligible Dependents, if any, are entitled to participate.

Benefit Program Material
"Benefit Program Material" means the most current provisions describing the Benefit Programs offered through this Plan. Notwithstanding any implication or statement to the contrary in any of the Benefit Program Material incorporated herein by reference, which may from time to time refer to such benefits as a "plan," the Plan is a single plan.

Charter
"Charter" means the Charter of the City and County of San Francisco.

Child
"Child" means the child of a Participant as further defined in Section 2.2.

COBRA
"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and regulations promulgated thereunder as they now exist, or may be amended from time to time.

Code
“Code” means the Internal Revenue Code of 1986, as amended, and regulations promulgated thereunder as they now exist, or may be amended from time to time.

Covered Employee
"Covered Employee" means a Covered Employee as set forth in the definition of "Qualified Beneficiary."

Compensation
“Compensation” means the total cash remuneration received by the Participant from the Employer during a Plan Year prior to any reductions pursuant to a Salary Reduction Agreement authorized in this Plan; provided, however, Compensation shall not include cash remuneration received before the Participant began participation in the Plan.

Contributions
“Contributions” means the contributions taken from the Participant’s salary on a before-tax basis, pursuant to a Salary Reduction Election.

Dependent
"Dependent" means an individual as defined in Section 2.3.

Dependent Care Flexible Spending Account (Dependent Care FSA)
“Dependent Care Flexible Spending Account (Dependent Care FSA)” means the Dependent Care Flexible Spending Account described in Appendix C of this Plan, or as it may be amended from time to time.

Domestic Partner
“Domestic Partner” means a partner as further defined in Section 2.3.

Effective Date of First Adoption of Plan
“Effective Date of First Adoption of Plan” means December 1, 1988.

Effective Date of This Amendment and Restatement
“Effective Date of this Amendment and Restatement” means July 1, 2012.

Eligible Child
“Eligible Child” means an Eligible Child as set forth in Section 2.3.

Eligible Dependent
“Eligible Dependent” means an Eligible Dependent as set forth in Section 2.3.

Eligible Domestic Partner
“Eligible Domestic Partner” means a Domestic Partner as further defined in Section 2.3.

Eligible Employee
“Eligible Employee” means a regular Employee who is eligible to participate as set forth in Section 2.2, unless such Employee does not qualify pursuant to applicable law, as eligible to participate in an Internal Revenue Code Section 125 plan.

Notwithstanding any other provision, an Eligible Employee under this Plan does not include: (i) a temporary or "as needed" employee who is not scheduled for, or who has not earned, more

than one thousand and forty (1,040) hours of compensation during any consecutive twelve (12) month period.; (ii) a leased employee within the meaning of Code Section 414(n); (iii) a nonresident alien with no U.S. source of income; (iv) an individual who is not on the U.S. payroll of the Employer; (v) an individual employed pursuant to a written agreement which provides that such individual shall not be eligible for participation in the Plan; (vi) an independent contractor; or (vii) any other individual whose compensation is not fixed by the San Francisco Board of Supervisors or by statue or whose compensation is not paid by the City or a Participating Employer.

Eligible Spouse
"Eligible Spouse" means a Spouse as further defined in Section 2.3.

Employee
"Employee" means a common law employee of the Employer who is categorized as an Employee by the City and County of San Francisco Department of Human Resources (or by the appropriate governing body with respect to each Participating Employer), and whose compensation is fixed by statute and/or by the San Francisco Board of Supervisors (or by the appropriate governing body with respect to each Participating Employer), and whose compensation is paid by the City or a Participating Employer. The term "Employee" shall exclude any individual, including a leased individual or an independent contractor, during any period he or she is not classified as a common-law employee by the Employer, without regard to whether such an individual is subsequently determined by a state or federal court or agency to have been a common-law employee of the Employer for tax or any other legal purpose during such period.

Employer
"Employer" means the City and County of San Francisco and all Participating Employers.

ERISA
"ERISA" means Public Law No. 93 406, the Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated thereunder as they now exist, or from time to time may be amended.

Experience Gain
"Experience Gain" means the excess of required Premiums paid and income (if any) over the total claims reimbursements and reasonable administrative costs for the Plan Year.

Health Care Flexible Spending Account (Health Care FSA)
"Health Care Flexible Spending Account (Health Care FSA)" means the Health Care Flexible Spending Account described in Appendix B of this Plan, or as it may be amended from time to time.

HIPAA
"HIPAA" mean the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations promulgated thereunder as they now exist or from time to time may be amended.

Health Service System
"Health Service System" means the San Francisco Health Service System.

Health Service System Benefit Programs
"Health Service System Benefit Programs" means Benefit Programs under this Plan offered through the Health Service System.

Health Service System Rules
"Health Service System Rules" means the rules as approved by the Health Service System Board, as they may be amended from time to time, which are, as applicable to this Plan, hereby incorporated by reference. See Appendix F for the Health Service System Rules website address current as of the date of this amendment and restatement.

Participant
"Participant" means an Eligible Employee who participates in the Plan pursuant to Articles II and III and has not for any reason become ineligible to participate further in the Plan.

Participating Employer
"Participating Employer" means a public entity affiliated with the City and County of San Francisco as determined from time to time by a properly adopted Charter Amendment, or Ordinance of the City and County of San Francisco, to participate in this Plan without written amendment to this Plan. As of January 1, 2013, the Participating Employers include, but are not limited to:

(a) City and County of San Francisco Unified School District;
(b) San Francisco Community College District;
(c) Superior Court of California County of San Francisco

Period of Coverage
"Period of Coverage" means the Plan Year, unless otherwise provided in this document, e.g., in the case of a Qualifying Status Change Event or a newly hired Eligible Employee.

Plan
"Plan" means the City and County of San Francisco Section 125 Cafeteria Plan, the terms of which are set forth herein, as it may be amended from time to time.

Plan Administrator
"Plan Administrator" shall mean the Health Service System for purposes of the administration of this Plan and for Benefit Programs under this Plan which are offered by the HSS and are permitted to be offered under Code section 125. The Health Service System may delegate plan administration duties and/or responsibilities pursuant to Article VII of this Plan to others, including a Participating Employer.

Plan Sponsor
"Plan Sponsor" shall mean the City and County of San Francisco.

Plan Year
The term "Plan Year" shall mean the twelve (12) month period beginning on each January 1 and ending on December 31.

Premium Conversion Benefit Component
"Premium Conversion Benefit Component" means the Premium Conversion Benefit Component described in Appendix A of the Plan, or as it may be amended from time to time.

Premium Expenses
"Premium Expenses" or "Premiums" mean the Participant's cost for the insured Benefits described in Section 6.1.

Qualified Beneficiary
A "Qualified Beneficiary" is a person who is covered under the Plan on the day before a Qualifying Event who is:

(a) an Eligible Employee who is covered under the Plan (hereinafter referred to as "Covered Employee");
(b) a spouse of a Covered Employee; or
(c) a dependent child of a Covered Employee (including a child born to or placed for adoption with the Covered Employee while the Covered Employee is covered under continuation coverage).

Qualifying Status Change Event
“Qualifying Status Change Event” means a change in an Eligible Employee’s status as described in Section 4.5 of this Plan.

Salary Reduction
“Salary Reduction” means a specified amount by which a Participant’s Compensation is decreased, pursuant to a Salary Reduction Election, for federal income tax and Social Security tax purposes and, wherever permitted, under applicable law for state and local income tax purposes.

Salary Reduction Election
“Salary Reduction Election” means the authorization to the Employer by the Eligible Employee to reduce his or her pay by an amount on a before-tax basis for selected Plan benefits.

Security Incident
“Security incident” shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI.

Spouse
“Spouse” means the legally married partner of a Participant as further defined in Section 2.3.

ARTICLE II
ELIGIBILITY

2.1 Eligibility in General

Eligibility of Employees shall be determined as set forth in the Health Service System Rules, as approved by the City and County of San Francisco Health Service System Board, effective July 1, 2016 (Health Service System Rules). The Health Service System Rules may be amended from time to time without formal amendment to this Plan document.

2.2 Eligible Employee

(a) Eligible Employee shall mean with respect to Health Service System Benefit Programs, an Employee eligible pursuant to the Health Service System Rules.

(b) Eligible Employees shall be eligible to participate in the Plan with respect to Health Service System Benefit Programs, the date they become entitled to membership in the Health Service System pursuant to the Health Service System Rules.

(c) Eligible Employees shall be the only individuals permitted as Participants in the Plan.

(d) Rehired former Participants shall be treated as new Employees for the purposes of Plan eligibility if rehired more than 30 days after termination. A former Participant who terminates employment with the Employer and then returns to employment with the Employer as a Participant within 30 days following his or her termination of employment, shall be reinstated in his or her elections under the Plan prior to the termination. If such former Participant returns to employment with the Employer within 30 days following his or her termination of employment and such person's absence spans 2 Plan Years, the Participant will be covered under the Plan immediately upon reemployment provided that the Participant must reenroll in the Plan and make a new election for the remainder of the Plan Year.

(e) Notwithstanding the foregoing, the Health Service System shall make eligibility determinations with respect to employees of the City and County of San Francisco. The appropriate governing body shall make eligibility determinations with respect to each Participating Employer. Each Participating Employer shall determine which Health Service System Benefit Programs are available for its employees.

2.3 Eligible Dependents

The following are Eligible Dependents under the Plan:

(a) Eligible Spouse shall mean an Eligible Employee’s Legal Spouse as defined in the Health Service System Rules with respect to Health Service System Benefit Programs;

(b) Eligible Domestic Partner shall mean an Eligible Employee’s Legal Domestic Partner as defined in the Health Service System Rules with respect to Health Service System Benefit Programs.

(c) Eligible Child shall mean an individual described in the Health Service System Rules with respect to Health Service System Benefit Programs.

ARTICLE III
PLAN PARTICIPATION

3.1 Effective Date of Participation

(a) An Eligible Employee shall be eligible to participate in the Plan on the date the individual becomes an Eligible Employee.

Participation, or a change in election, as applicable, shall be effective in a Benefit Component as applicable, as set forth in the Health Service System Rules.

The effective date of participation, or change in election, as applicable, shall only be effective if the Eligible Employee completes the enrollment procedure, or change in election as applicable, in accordance with the timeframe and manner prescribed by the Plan Administrator (or its delegate) to elect to participate (or change an election).

(b) Notwithstanding the foregoing, participation, or a change in election, as applicable, shall be effective in a Benefit Component on the date an Eligible Child is newly acquired due to birth, adoption, or placement for adoption, provided that all applicable conditions of the special enrollment rules of the HIPAA are satisfied and, provided further, that an election form is submitted in accordance with the timeframe and manner prescribed by the Plan Administrator, or its delegate, to elect to participate in the Plan.

3.2 Election to Participate

(a) Participation in this Plan by an Eligible Employee shall be contingent upon participation in a Benefit Component, and receipt by the Plan Administrator, or its delegate, of such applications, consents, proofs of birth or marriage, elections, beneficiary designations, proof of reimbursable expenses and other documents and information as required by this Plan, the Plan Administrator, or the Plan Administrator's delegate.

(b) The election made shall be irrevocable until the end of the applicable Plan Year, unless the Participant is entitled to change his or her election(s) pursuant to a Qualifying Status Change Event.

(c) An Eligible Employee shall also be required to execute a Salary Reduction Election during the Annual Open Enrollment Election Period for the Plan Year during which he or she wishes to participate in the Plan.

(1) Any such Salary Reduction Election shall be effective for the first pay period beginning on or after the Eligible Employee's effective date of participation pursuant to Section 3.1.

(2) Participants who do not have sufficient salary to enter into a Salary Reduction Agreement shall make applicable after-tax premium payments directly to the Plan Administrator within the designated time period.

3.3 Authorized Leaves of Absence

(a) A Participant who goes on an authorized leave of absence, including authorized unpaid leave as set forth in the Health Service System Rules, may continue to receive group health benefit coverage under the Benefit Programs and the Health Care FSA as long as the Participant contributes the applicable premium payments or FSA contributions within the designated time period.

(b) Contributions for the period covered by the leave of absence may be paid for in a manner consistent with applicable law and in accordance with the terms as set forth in the Health Service System Rules.

(c) Upon return from an authorized leave of absence during which the required contributions under the Plan by a Participant are not made, the Participant's reinstatement shall be determined in accordance with the rules set forth in Section 3.6.

3.4 USERRA (Military) Leaves of Absence

(a) A Participant who goes on an unpaid military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue to receive group health benefit coverage under the Benefit Programs and the Health Care FSA during the USERRA leave until the earlier to occur of: (a) the day after the date on which the Participant fails to return to employment, as described in USERRA (United States Code Chapter 43 of Title 38); or (b) twenty-four (24) months from the date of commencement of the USERRA leave.

(b) If the USERRA leave is less than 31 days, Participants' required contributions will remain the same as when they were actively employed.

(c) If the USERRA leave is 31 days or longer, Participants may be required to pay up to 102 percent of the full premium cost.

(d) Contributions for the period covered by the leave of absence may be paid for in accordance with the terms as set forth in the Employer's written materials distributed to Participants, and consistent with applicable law.

(e) Upon return from a USERRA leave during which the required contributions under the Plan by a Participant are not made, the Participant's reinstatement shall be determined in accordance with the rules set forth in Section 3.5.

3.5 Cancellation and Suspension of Participation

(a) A Participant who goes on an authorized leave of absence from the Employer during the Plan Year:

(1) May choose to cancel or suspend group health benefit coverage under the Benefit Programs and the Health Care FSA effective upon commencement of the leave of absence.

(2) Participation in the Dependent Care FSA will be automatically suspended upon the commencement of a leave of absence.

(b) During periods of cancelled, or suspended, participation, no contributions shall be made and no benefits shall be provided under the Plan, except as otherwise explicitly stated in a Benefit Program or as required by COBRA.

(c) A Participant who returns to an Employer's service during the same Plan Year that he or she took an unpaid authorized leave of absence shall be eligible to be reinstated in the Benefit Programs and in the Health Care FSA and the Dependent Care FSA in effect when his or her participation was suspended. However, a suspended Participant's participation in the Plan shall terminate if, after return to employment following the end of a leave of absence, the Participant does not resume coverage as set forth in the Employer's written materials distributed to Participants, consistent with applicable law.

(d) With respect to the Health Care FSA and the Dependent Care FSA, a Participant who suspended participation in the Health Care FSA and/or the Dependent Care FSA during his or her leave of absence may elect to increase his or her required contributions for the remainder of the Plan Year by the amount of the contributions the Participant failed to make during the leave of absence. The amount of the increase shall be spread ratably over the remaining pay periods in the Plan Year. If such an election is made, the maximum reimbursement under the Health Care FSA and/or the Dependent Care FSA shall be the same amount with respect to expenses incurred both before and after the leave of absence. In the absence of such an election, the Participant, upon returning from leave, shall resume his or her required contributions for the remainder of the Plan Year at the same level being made prior to the leave of absence, and the maximum reimbursement for expenses incurred after the leave of absence shall be reduced by the amount of the required contributions the Participant failed to make during the leave of absence. Regardless of what election is made, if coverage is suspended during the leave of absence, no expenses incurred during the leave will be reimbursed under the Plan.

3.6 Termination and Reinstatement of Participation

Except as otherwise provided in a Benefit Program, in the event an Eligible Employee who has made an election under the Plan ceases to be an Eligible Employee, takes an unauthorized leave of absence, or ceases to have enough Compensation to cover his or her salary reduction under the Plan, and does not make applicable premium payments to the Plan Administrator within the designated time period, such person's election and coverage under the Plan shall terminate.

(a) If the Employee becomes eligible to participate: (i) within 30 days of the date on which his participation was terminated; and (ii) within the same Plan Year, his or her active participation in the Plan shall be reinstated and the most recent election shall remain in effect, except as otherwise permitted pursuant to Section 3.5.

If such Employee becomes eligible to participate: (i) more than 30 days after the date on which participation terminated; or (ii) in a subsequent Plan Year, such person shall be treated as a newly Eligible Employee, and shall be permitted to make a new election under the Plan.

(b) Except for the Health Care FSA and the Dependent Care FSA, participation in the Plan shall terminate as of the earlier of:

1. The date of termination of the Plan, unless otherwise communicated to Participants; or

2. The last day of the coverage period in which the Eligible Employee ceases to be a Participant in all Benefit Programs.

3. The date on which the Participant stops making any required contributions (except where otherwise allowed by the Plan).

3.7 Termination of Employment

If a Participant terminates employment with an Employer for any reason other than death, his or her participation in the Plan shall cease as of the last day of the pay period in which such termination occurs, subject to the Participant's right to continue coverage under any insurance contracts for which the Premiums have already been paid. However, such Participant may submit claims for expenses incurred prior to termination for the remainder of the Plan Year in which such termination occurs.

3.8 Death

If a Participant dies, his or her participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the portion of the Plan Year preceding his date of death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may designate the Participant's Eligible Spouse, Eligible Domestic Partner, or Eligible Child or a representative of his estate.

3.9 Continuation Coverage (COBRA)

(a) COBRA coverage under the Health Care FSA and the Benefit Programs for which COBRA is offered shall be extended and financed in accordance with the administrative procedures adopted by the Employer to comply with applicable law and with the group health plans sponsored by the Employer. Appendix B provides additional detail regarding COBRA benefits as related to the Health Care FSA.

(b) To the extent required by COBRA, if a person ceases to be an Eligible Employee and agrees to pay the premium for COBRA continuation coverage, the person shall be treated as a Participant to the extent required by law, and coverage under the Health Care FSA shall continue for as long as such premiums are paid, if applicable, but not beyond the Plan Year in which the COBRA qualifying event occurs, subject to the terms and conditions of the Plan.

ARTICLE IV
ELECTIONS TO PARTICIPATE

4.1 In General

The Plan Administrator, or its delegate, shall establish procedures and deadlines for filing Salary Reduction Elections.

4.2 Salary Reduction Election

Each Eligible Employee who wishes to participate shall timely file a Salary Reduction Election with the Employer. The election shall provide that the Participant's Compensation in each payroll period shall be reduced by a specific amount; provided, however, that the amount shall not exceed the lesser of the limits set forth in such individual's elected Benefit Components, or the Participant's Compensation for that payroll period. Except as provided in Section 4.5, a Participant's Salary Reduction Election shall be irrevocable for a Plan Year.

4.3 Default Elections

(a) Premium Conversion. Unless provided otherwise by Employer, if a Participant does not make a new election with respect to the Benefit Programs during an Annual Enrollment Period, the Participant's coverage under the Benefit Programs will remain the same and will continue to apply during the next Plan Year; provided, however, that the amount of the reduction in the Participant's Compensation for such subsequent Plan Year to pay for such Benefit Program shall be adjusted automatically in the event of a change in the cost of the coverage.

(b) Health Care Flexible Spending Account, Dependent Care Flexible Spending Account Component. If a Participant does not make a new election with respect to the Participant's coverage under the Health Care FSA or the Dependent Care FSA Component, such coverage shall cease on the last day of the Plan Year.

4.4 Compensation in Lieu of Election to Participate

Eligible Employees who do not elect to participate in a Benefit Component shall receive their regular taxable cash Compensation in lieu of benefits.

4.5 Qualifying Status Change Events

A Participant's Salary Reduction Election for any Plan Year may not be changed after the first payroll period to which it applies, except for events constituting a Qualifying Status Change Event as permitted by applicable law and set forth in the Health Service System Rules.

(a) The Eligible Employee must provide the Plan Administrator, or its delegate, with timely written documentation that a Qualifying Status Change Event has occurred.

(b) With respect to the Dependent Care FSA, the Plan Administrator may establish a maximum number of election changes made in a specified Plan Year, for any Participant by notifying all Participants of the maximum number. Any election

change requested by a Participant who has reached the maximum number for the applicable period shall be made only if such change request must be honored by applicable law.

4.6 Change of Election

(a) In the event of a Qualifying Status Change Event, an Eligible Employee may revoke or change his or her election in accordance with the time frame and the manner set forth in the Employer's written summary material and Health Service System Rules distributed to Participants as of the date such Qualifying Status Change Event occurs.

(b) In any case, if the Eligible Employee misses the deadline to revoke or change his or her election, the Eligible Employee must then wait until the next following Annual Open Enrollment Election Period or Qualifying Status Change Event, whichever occurs earlier, to make an election revocation or change.

(c) An election revocation or change must be due to, and consistent with, the Qualifying Status Change Event to the extent required by applicable law. The Plan Administrator, or its delegate, in its sole discretion, shall determine whether or not a requested election revocation or change is so due to, and consistent with, the Qualifying Status Change Event.

ARTICLE V
PLAN RECORDKEEPING

The Employer shall make all contributions required by the Benefit Components out of its general assets. The Employer will retain title to, and beneficial ownership of, assets which are earmarked for payment of benefits under this Plan. No pre-funding of benefits will be required.

For bookkeeping purposes only, the Plan Administrator, or its delegate, will maintain an account for each Participant. This account will be divided into sub-accounts which will be credited with the amount of Salary Reduction specified by such Participant for each Benefit Component.

ARTICLE VI
BENEFITS

6.1 Benefits

Benefits under a Benefit Component shall be payable, or provided, for a Period of Coverage only if such benefits relate to, and such costs were incurred during, periods in which the individual has properly elected to participate in that Benefit Component. Amounts credited to each Benefit Component subaccount shall be payable in accordance with the terms of the Benefit Component.

6.2 Benefit Program Options

Each Participant may elect to participate in one or more of the Benefit Programs that may be authorized from time to time by the Employer. Changes to the Benefit Programs may be made without formal amendment to this Plan.

The Health Service System Benefit Program complies with Charter § A8.422 to include benefits that render medical care such as medical plans, dental plans, vision plans, and long term disability plans. Additionally, other benefits administered under the Health Service System Benefit Program include flexible credits, life insurance, flexible spending accounts, long term care insurance, and others as set forth in Appendix E.

ARTICLE VII
PLAN ADMINISTRATION

7.1 Plan Administrator

(a) The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, to correct errors, and to construe and interpret Plan provisions including, but not limited to, determinations regarding eligibility and benefits.

(b) The Plan Administrator may delegate duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the Plan Administrator expressly provides to the contrary, such delegation will carry with it the Plan Administrator's full discretionary authority to accomplish the delegation.

(c) All decisions and interpretations of the Plan Administrator shall be conclusive and binding upon all persons, and shall be given the greatest deference permitted by law. Benefits under the Plan will be paid only if the Plan Administrator or its designee decides in its sole discretion that a Participant is entitled to such benefits, or that an Employee is an Eligible Employee.

7.2 Payment Of Expenses

All proper expenses incurred in administering the Plan will be paid by the Plan, unless paid by the Employer, unless the Plan or the Employer (as applicable) determines that administrative costs shall be borne by the Participants under the Plan consistent with applicable Federal, State and local law. The Plan Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated Employees.

7.3 Insurance Control Clause

In the event of a conflict between the terms of this Plan and the terms of an insurance contract, including the Health Services System rider of a particular insurer whose product is then being used in conjunction with this Plan, the terms of the insurance contract including the Health Services System rider shall control as to those Participants receiving coverage under such insurance contract. For this purpose, the insurance contract, including the Health Services System rider, shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to, and the circumstances under which insurance terminates.

7.4 Benefits of Unlocated Persons

If a payment is due under the Plan, and if notice of such payment due is mailed to the last known address of such person, as shown on the Plan records, and within six (6) months after such mailing such person has not made written claim therefore, the Plan Administrator shall, unless otherwise provided in the Benefit Program Materials, direct that such payment and all remaining contributions otherwise due to such person be canceled, and upon such cancellation, the Plan shall have no further liability therefore.

7.5 Experience Gains

(a) If the Health Care FSA has an Experience Gain with respect to a Plan Year, such Experience Gain may be used to pay expenses of the Health Care FSA, or other Plan expenses as otherwise determined by the Plan Administrator, consistent with applicable laws and regulations.

(b) If the Dependent Care FSA has an Experience Gain with respect to a Plan Year, such Experience Gain may be used to pay expenses of the Dependent Care FSA, or other Plan expenses as otherwise determined by the Plan Administrator, consistent with applicable laws and regulations.

(c) In no event shall Experience Gains be allocated among Participants based, directly or indirectly, on the level of their Health Care FSA or Dependent Care FSA reimbursement amounts.

7.6 Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Eligible Employees and then from amounts contributed by the Employer.

ARTICLE VIII
CLAIMS

8.1 Claims Procedures

(a) The claims procedure set forth in the Health Service System Rules shall govern eligibility claims for Benefit Programs under this Plan.

(b) Any claim for benefits provided under an insurance contract issued by the insurer shall be made to the insurer. If the insurer denies any claim, the Participant or beneficiary shall follow the insurer's claims review procedure.

(c) Any other claim for Benefits shall be made in a manner determined by the Plan Administrator. See also additional claims procedures for the Health Care FSA and the Dependent Care FSA set forth in Appendix B and Appendix C, respectively.

ARTICLE IX
HIPAA PRIVACY AND SECURITY

9.1 Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the regulations issued thereunder, impose obligations on group health plans with respect to protected health information ("PHI") and electronic protected health information ("e-PHI") as defined in 45 CFR Parts 160 and 164 ("the HIPAA regulations").

9.2 Plan Subject to HIPAA

In this Article IX, "Plan" includes the group health benefit offerings by the City and County of San Francisco, including the group health care components of this City and County of San Francisco Section 125 Cafeteria Plan.

9.3 Uses and Disclosures of PHI

The Plan and the Plan Administrator may disclose a Plan Participant's PHI to Plan Sponsor (or to Plan Sponsor's agent) for the following Plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations:

(a) Customer service assistance with claims issues;

(b) Plan management, quality assessment and auditing.

The Plan will not provide PHI to a Participating Employer without the authorization of the individual who's PHI is being sought, as otherwise allowed by law in the Plan Administrator's discretion, or as required by law.

9.4 Restriction on Plan Disclosure of PHI to the Plan Sponsor

The Plan, its Business Associates, health insurance issuers, or HMOs, will not disclose PHI to the Plan Sponsor except upon the Plan's receipt of the Plan Sponsor's certification that the Plan has been amended to incorporate the agreements of the Plan Sponsor under Section 9.6 below, and/or except as otherwise permitted or required by law. A copy of this Plan document may serve as such certification.

9.5 Privacy Agreements of the Plan Sponsor

As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Plan Sponsor agrees it will:

(a) Not use or further disclose such PHI other than as permitted by Section 9.4 as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

(b) Require that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(d) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(e) Make the PHI of a particular Participant or other enrollees available for purposes of their written requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation Sections 45 CFR 164.524 and 164.526;

(f) Make the PHI of a particular Participant or other enrollees available for purposes of required accounting of disclosures by the Plan Sponsor pursuant to their requests for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

(g) Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations;

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

(i) Require that there is adequate separation between the Plan and the Plan Sponsor by implementing the terms of (1) through (3), below:

(1) *Employees with access to PHI*: The following employees, or other individuals under the control of Health Service System, are the only individuals that may access PHI received from the Plan:

a. All Health Service System personnel for Plan administration purposes;
b. Finance personnel for Plan administration purposes;
c. Staff of office of the City Attorney who assist Health Service System and/or Finance with Plan administration purposes;
d. Staff of the City Department of Technology who provide technical assistance or support to Health Service System and/or Finance.

(2) *Use Limited to Plan Administration*: The access to, and use of, PHI by the individuals described in (1), above, is limited to Plan Administration functions defined in HIPAA regulation 45 CFR 164.504(a).

(3) *Mechanism for Resolving Noncompliance*: If the Plan Sponsor, Plan Administrator, or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this Article VII, then such individual shall be disciplined in accordance with the Plan Sponsor's standard disciplinary policies and procedures, as those policies and procedures may be amended from time to

time. The Plan Sponsor shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

9.6 Security Provisions of the Plan Sponsor

The Plan Sponsor who receives e-PHI shall in accordance with HIPAA and related regulations:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Require that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Require that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

(d) Report to the Plan any Security Incident of which it becomes aware. “Security incident” shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

(e) Upon request from the Plan, the Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Plan Sponsor.

9.7 PHI and e-PHI not Subject to the Provisions of Article IX

Notwithstanding the foregoing, the terms of this Article IX shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); or to PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted under Federal law.

9.8 Definitions

All capitalized terms within this Article IX not otherwise defined by the provisions of this Article shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

ARTICLE X
MISCELLANEOUS

10.1 Nondiscrimination

The Plan Administrator may unilaterally change or revoke any election by an Eligible Employee if the Plan is, or is likely to become, discriminatory or to otherwise violate applicable law.

10.2 Notice

Any notice to be delivered under this Plan shall be given in writing and delivered, personally, by facsimile or, by certified mail, postage prepaid, addressed to the Plan Administrator, the Participant, or any beneficiaries, as the case may be, at their last known address. Nothing herein shall prevent the use of electronic or such other forms of notification as the Plan Administrator may choose to employ.

Notice to the Plan Administrator shall be addressed as follows:

Director
Health Service System
1145 Market Street, Suite 200
San Francisco, CA 94103

With a copy to:

Health Service System General Counsel
Office of the City Attorney
City Hall, Room 234
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

10.3 Captions

The captions of the sections of this Plan are for convenience only, and shall not control the meaning or construction of any of its provisions.

10.4 Severability of Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provisions had not been included.

10.5 Governing Law

This Plan shall be construed and enforced in accordance with the Code to the extent it is not preempted by federal law, with the laws of the State of California and the Charter and the ordinances of the City and County of San Francisco. Any action relating to, arising out of, or involving, the Plan shall be litigated in a state or federal court located in San Francisco County, California.

10.6 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun shall include the opposite gender, the singular shall include the plural, and the plural shall include the singular, whenever the context shall plainly so require.

10.7 Separate Plans

To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of the Code, and any privacy and security laws, each coverage level, each group of employees covered by the Plan, and each class of benefits provided under the Plan, will constitute a separate "plan."

10.8 Right to Offset Future Payments

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

10.9 Right to Recover Payments

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

10.10 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

10.11 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Participants.

10.12 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted (or required) to do (or perform) any act of matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

10.13 Additional Taxes or Penalties

If there are any taxes or penalties payable by the Employer on behalf of any Participant, such taxes or penalties shall be payable by the Participant to the Employer to the extent such taxes would have been originally payable by the Participant had this Plan not been in existence.

10.14 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal, state, or local income tax purposes or for social security tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether payment under the Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and social security tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not excludable.

10.15 Indemnification Of Employer By Participants

If a Participant receives one or more reimbursements under his or her Dependent Care FSA that are not for Dependent Care Expenses or under his or her Health Care FSA that are not for Qualifying Medical Expenses, the Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from the reimbursements; provided, however, the Participant's indemnification and reimbursement shall not exceed the amount of additional federal, state, or local income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.16 Limitation of Rights and Obligations

Neither the establishment nor maintenance of the Plan, nor any amendment thereof, nor any act or omission under the Plan resulting from the operation of the Plan shall be construed:

(a) as conferring upon any Participant, beneficiary, or any other person a right or claim against the Employer, the Plan Administrator, or a designee, except to the extent that such right or claim shall be specifically expressed or provided in the Plan;

(b) as creating any responsibility or liability of any Employer, the Plan Administrator or a designee for the validity or effect of the Plan;

(c) as a contract or agreement between any Employer and any Participant or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Participant or other person to continue or terminate the employment relationship at any time;

(e) as to give any Participant or other person, the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or other person at any time.

10.17 Misrepresentation

Any material misrepresentation on the part of the Participant making application for coverage or receipt of benefits, shall render the coverage null and void.

10.18 Employment of Consultants

The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

10.19 Designation of Fiduciaries

The Plan Administrator may designate another person or persons to carry out any fiduciary responsibilities of the Plan Administrator under the Plan. The Plan Administrator shall not be liable for any act or omission of such person in carrying out such responsibility.

10.20 Counterparts

The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument, and shall be evidenced by any one counterpart.

10.21 Disclaimer of Liability

Nothing contained herein shall confer upon a Participant any claim, right, or cause of action, either at law or at equity, against the Plan, Plan Administrator, a designee, or any Employer, for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

10.22 Legal Counsel

The Plan Administrator, and/or its designee, may from time to time consult with counsel, who may be counsel for the Employer, and shall be fully protected in acting upon the advice of such counsel.

10.23 Protective Clause

Neither the Employer, the Plan Administrator, nor a designee shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider, or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

10.24 Receipt and Release

Any payments to any Participant shall, to the extent thereof, be in full satisfaction of the claim of such Participant being paid thereby. The Plan Administrator, or a designee may condition payment thereof on the delivery by the Participant of the duly executed receipt and release in such form as may be determined by the Plan Administrator, or a designee.

10.25 Legal Actions

If the Plan Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Plan Administrator in connection with such proceeding shall be paid by the Employer.

10.26 Reliance

The Plan Administrator a designee shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Plan Administrator or a designee to be genuine or to be executed or sent by an authorized person.

10.27 Participant Incapacitation

When any Participant is under legal disability or, in the Employer's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Employer may cause the Participant's benefits to be paid to his legal representative for his or her benefit. The payment of benefits pursuant to this Section shall completely discharge the liability of the Employer for the benefits.

10.28 Rules of Interpretation

The Plan is to be administered consistent with Code Section 125. The Medical Flexible Spending Account is to comply with the requirements of Code Sections 105 and 106 and the Dependent Care Flexible Spending Account is to comply with the requirements of Code Section 129. The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, to correct errors, and to construe and interpret Plan provisions including, but not limited to, determinations regarding eligibility and benefits. All decisions and interpretations of the Plan Administrator shall be conclusive and binding upon all person, and shall be given the greatest deference permitted by law.

10.29 Entire Plan

The Plan document, and the documents incorporated by reference herein, will constitute the only legally governing documents for the Plan. All statements made by any Employer or Administrator will be deemed representations and not warranties. No oral statement or other communication will void or reduce coverage under the Plan, or amend or modify the terms of the Plan, or be used in defense to a claim, unless in writing signed by the Administrator.

ARTICLE XI
AMENDMENT AND TERMINATION

11.1 Amendment

The Plan Sponsor, Plan Administrator, or its authorized delegate, may amend any or all of the provisions of the Plan, any Benefit Program, or any contract providing benefits without the consent of any Employee, Participant or Participating Employer at any time. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment complies with federal, state or local laws, statutes or regulations.

The Plan Sponsor, or its authorized delegate, may also remove or change any insurance company or health maintenance organization at any time.

11.2 Termination

A Participating Employer, or its authorized delegate, may terminate or partially terminate its participation in the Plan, or any Benefit Program, over which it has administrative discretion, or reduce or discontinue its Employer contributions at any time consistent with federal, state or local laws, statutes, regulations and Health Service System Rules. Any such decision by a Participating Employer shall be evidenced in a writing by the governing body of the Participating Employer (or its delegate) that shall be filed with the Health Service Board no later than April 1 of the year prior to the effective date of the termination. When a termination resolution is provided, it must be sent to the Health Service System and it will, irrevocably, terminate such coverage for the applicable Participating Employer's employees, dependents and retirees effective the end of the Plan Year in which the notice is provided. In addition, the Participating Employer will not be eligible to resume participation for five (5) Plan Years after the effective date of its termination of participation. The Health Service Board, in its sole discretion, may waive or reduce the time period referenced in this paragraph. Notwithstanding any other provision of this Plan, the Health Service Board, or the authorized delegate, may terminate or partially terminate the Plan or any Benefit Program, or reduce or discontinue Employer contributions at any time consistent with federal, state or local laws, statutes, regulations, and Health Service System Rules, and without the consent of any Employee, Participant or Participating Employer.

ARTICLE XII
EXECUTION

In Witness Whereof, the San Francisco Health Service System has caused this amended and restated City and County of San Francisco Section 125 Cafeteria Plan document to be duly executed effective as of January 1, 2019.

By: Abbie Yant Executive Director
San Francisco Health Service System

APPENDIX A

PREMIUM CONVERSION

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION A1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Premium Conversion Benefit Component incorporates by reference all the provisions of the Plan.

SECTION A2
ELIGIBILITY AND PARTICIPATION

The election by an Eligible Employee must include an election to be covered by a Benefit Program that results in a Salary Reduction. Each Participant will be deemed to have made a written Salary Reduction Election to have his or her annual Compensation reduced, but not below zero, by the amount of the Benefit Program Premiums the Participant is required to pay. Each Participating Employer shall determine which Benefit Programs under the Premium Conversion Benefit Component are available for their respective Eligible Employees.

SECTION A3
BENEFITS

A3.1 Plan Benefits

Salary Reduction amounts shall be applied to pay the amount of any Benefit Program Premium for Employee and/or Dependent coverage otherwise payable by a Participant each payroll period during the Period of Coverage.

A3.2 Limit on the Amount of Salary Reduction to be credited to the Premium Conversion Benefit Component

The total annual benefit under the Premium Conversion Benefit Component for a Participant shall not exceed the total of all Benefit Program Premiums for Benefit Programs in which the Participant is enrolled.

APPENDIX B

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA)

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION B1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Health Care Flexible Spending Account (Health Care FSA) incorporates by reference all the provisions of the Plan.

B1.1 Establishment of Plan

(a) This Health Care Flexible Spending Account Plan is intended to qualify as a medical reimbursement plan under Code Section 105, and shall be interpreted in a manner consistent with Code Section 105 and the Treasury regulations thereunder.

(b) Participants who elect to participate in this Health Care Flexible Spending Account Plan may submit claims for the reimbursement of medical expenses. All such amounts reimbursed under this Health Care Flexible Spending Account Plan shall be paid from amounts allocated to the Participant's Health Care Flexible Spending Account.

SECTION B2
DEFINITIONS

Definitions in the Plan apply to this Health Care FSA, with the following additions:

B2.1 Eligible Dependent

"Eligible Dependent" means a Participant's Eligible Spouse, Eligible Domestic Partner and/or Eligible Child provided such individual also qualifies for tax-free health coverage under the Code.

B2.2 Medical Expense

"Medical Expense" means an amount paid for medical care (including dental care, vision care and non-prescription drugs) within the meaning of Code Section 213(d) and as allowed under Code Sections 105 and 106(f) and the rulings, and Treasury regulations, thereunder. Effective January 1, 2011, an amount paid for a non-prescribed drug, except insulin, is not a Qualifying Medical Expense.

B.2.3 Qualifying Medical Expense

"Qualifying Medical Expense" means a Medical Expense for which the Participant or any Eligible Dependent has not been reimbursed, and which has been incurred and paid for by the Participant or by a Participant's Dependent. The Participant or Eligible Dependent must have a legal obligation to pay the expense, and the expense must not be eligible for reimbursement through insurance or otherwise. Qualifying Medical Expenses do not include:

(a) Premiums paid by a Participant, or an Eligible Dependent, for coverage under any group health plan or under an individual plan/policy; or

(b) Premiums paid by a Participant or a Dependent for long term care benefits described in Code Section 7702B(c) or coverage for any product which is advertised, marketed, or offered as long-term care insurance; or,

(c) Effective January 1, 2011, amounts paid for non-prescribed drugs, except insulin, as provided in Section B.2.2, above.

SECTION B3
BENEFITS

B3.1 Maximum Contribution and Uniform Benefit

(a) Maximum Contribution

(1) Period of Coverage effective on first day of Plan Year

a. The Maximum Contribution for an Eligible Employee whose participation becomes effective on the first day of the Plan Year shall not exceed $2,750~~0~~0 during a Period of Coverage.

(2) Period of Coverage effective after the first day of the Plan Year

a. The Maximum Contribution of a Participant whose Period of Coverage begins after the first day of the Plan Year shall not exceed $229.17~~25~~.00 per month for each month of participation remaining in the Plan Year.

(b) Pursuant to the "uniform benefit rule", the Maximum Contribution elected by the Participant under the Health Care FSA shall be available at all times during the Period of Coverage (properly reduced as of any particular time for prior reimbursements for the same Period of Coverage).

B3.2 Minimum Contribution

The Minimum Contribution shall be no less than $10 per pay period for a Participant during the Period of Coverage.

B3.3 Health Care Flexible Spending Accounts

The Plan Administrator shall establish a Health Care Flexible Spending Account for each Participant who elects to participate in the Health Care Flexible Spending Account. The Health Care Flexible Spending Account shall be for bookkeeping purposes only, and except as otherwise required by law, amounts credited to a Participant's Health Care Flexible Spending Account shall remain a part of the Employer's general assets.

B3.6 Forfeiture of Unused Balances – Use or Lose Rule and Carryover

The amount in a Participant's Health Care Flexible Spending Account at the end of any Plan year, and after the processing of all claims for such Plan Year, shall be forfeited and may be used as described in the Plan provisions related to Experience Gains in Section 7.5. In such event, the Participant shall have no further claim to such amount for any reason.

Members who elected a health FSA with a remaining balance will be permitted to 'carryover' to the immediately following plan year between a minimum of $10 and a maximum of $5500 of any amount remaining unused. Carryover is defined as health FSA balance remaining after the run-out period of the plan year that the member elects to transfer to the next plan year health FSA, up to $5500. The carryover amount is moved into the health FSA balance for the next plan year. Carryover funds are available for one plan year only. Any unused carryover funds will be forfeited at the end of the plan year. In addition, the carryover of up to $5500 does not count against or otherwise affect the indexed salary reduction limit applicable to each plan year.

The Carryover of between a minimum of $10 and a maximum of $5500 may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over. For this purpose, the amount remaining unused carryover funds as of the end of the plan year is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period for the plan year.

B3.7 Military Reservist Distributions

A Participant ordered or called to active military duty (by reason of being a member of a reserve component as defined in section 101 of title 37, United States Code) for a period in excess of 179 days, or for an indefinite period of time, may elect to receive a Qualified Military Reservist Distribution as defined in Code Section 125(h)(2). The Qualified Military Reservist Distribution must be made on or after the date of the call, or order, to active military service, and prior to three calendar months after the end of the Plan Year in which the call or order to active military duty occurred.

(a) No Qualified Military Reservist Distribution shall be made to a Participant electing to continue Health Care FSA participation under Sections 3.3, 3.4 or 3.6.

(b) Participants may receive a Qualified Military Reservist Distribution by submitting a written request to the Plan Administrator, or its designee, prior to three calendar months after the end of the Plan Year in which the Participant was ordered or called to active military duty.

(c) A Participant electing to receive a Qualified Reservist Distribution shall terminate participation in the Health Care FSA on the date that the Participant makes such election. Such a former Participant may again participate in the Health Care FSA when he or she again becomes an Eligible Employee.

SECTION B4
CLAIMS DEADLINE

B4.1 Health Care Flexible Spending Account Claims

Claims under the Health Care FSA must be submitted pursuant to procedures established by the Plan Administrator, or its delegate, and no later than March 31 following the close of the Plan Year in which the costs were incurred, as the case may be. Claims must be supported by documentation requested by the Plan Administrator.

SECTION B5
TERMINATION OF PARTICIPATION

B5.1 Termination of Participation

Participation in this Health Care FSA shall terminate on the earliest of:

(a) The date of termination of the Plan, unless otherwise communicated to Participants;

(b) The date on which the Participant fails to be an Eligible Employee;

(c) The date on which the Participant fails to make any required FSA Contribution; or

(d) The end of the Plan Year.

SECTION B6
CONTINUATION OF COVERAGE

B6.1 Qualified Beneficiary

Only Qualified Beneficiaries may elect continuation coverage under the Plan after a Qualifying Event.

B6.2 Qualifying Events

The right to continued coverage is triggered by any of six Qualifying Events, which, but for the continued coverage, would result in a loss of coverage under the Plan. For purposes of this Article, a "Qualifying Event" occurs upon:

(a) The death of the Covered Employee;

(b) The termination (other than by reason of gross misconduct) of the Covered Employee's employment, or reduction of hours of a Covered Employee that would result in a termination of coverage under the Plan;

(c) The divorce or legal separation of the Covered Employee from the Covered Employee's Eligible spouse;

(d) The Covered Employee becoming entitled to Medicare benefits; or

(e) An eligible Child of the Covered Employee ceasing to be a dependent child under the eligibility requirements.

B6.3 Election of Continuation Coverage

Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. The election period shall begin on or before the date that the Qualified Beneficiary would lose coverage under the Plan due to the Qualifying Event, and shall not end before the date that is sixty (60) days after the later of: (a) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (b) the date on which notice of the right to continued coverage is sent by the Plan Administrator or its designee. The election of continuation coverage must be made on a form provided by the Plan Administrator or its

designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Plan Administrator or its designee. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event shall have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage.

Qualified Beneficiaries will not be offered an election to continue coverage under the Health Care FSA if, as of the date of the Qualifying Event, the amount remaining in the Health Care FSA for reimbursements is less than the amount that the Qualified Beneficiary would have to pay for continuation coverage under the Health Care FSA for the remainder of the Plan Year in which the Qualifying Event occurs. In determining the amount remaining in a Health Care FSA as of the date of a Qualifying Event, the claim reviewer will take the full amount credited to a Health Care FSA at the beginning of the Plan Year and subtract all of the reimbursements made from the Health Care FSA as of the date of the Qualifying Event. For example, assume that a Participant elected $1,200 at the beginning of the Plan Year and then terminated employment on June 30. Prior to June 30, the Participant was reimbursed for $1,000 in Qualifying Medical Expenses from his/her Health Care FSA. The Participant would not be offered continuation coverage because he/she would have to pay $612 in COBRA premiums for the rest of the Plan Year ($100 per month from July through December, plus a 2% administrative fee), but the Participant would only be able to receive another $200 in Qualified Medical Expense reimbursements (the $1,200 annual election reduced by the $1,000 in Qualified Medical Expense reimbursements the Participant received before the Qualifying Event).

B6.4 Period of Continuation Coverage

COBRA coverage under the Health Care FSA shall extend only until the end of the Plan Year in which the Qualified Beneficiary's Qualifying Event occurs.

B6.5 End of Continuation Coverage

Continuation coverage shall end earlier than the period designated under Section B6.4 (above) if:

(a) Timely payment of premiums for the continuation coverage is not made;

(b) The Qualified Beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA) with respect to any pre-existing condition of the Qualified Beneficiary;

(c) The Qualified Beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;

(d) The Employer ceases to provide any group health plan to any Employee;

(e) The Qualified Beneficiary ceases to be disabled, if continuation coverage is due to the disability;

(f) The period of continuation coverage expires; or

(g) As provided under Section 6.2

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

B6.6 Cost of Continuation Coverage

The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as "premium." The premiums are payable on a monthly basis. After a Qualifying Event, a notice shall be provided which shall specify the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within thirty (30) days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within forty-five (45) days after the date of election. Notice shall be given which shall specify the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have been terminated.

B6.7 Notification of Requirements

(a) General Notice to Covered Employee and Spouse. The Plan shall provide, at the time of commencement of coverage, written notice to each Covered Employee and to the spouse of the Covered Employee (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Covered Employee and the Covered Employee's spouse if they both reside at the Covered Employee address, and the spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided under this subparagraph (a). No separate notice is required to be sent to dependents who share a residence with a Covered Employee or a Covered Employee's spouse. This general notice shall be provided not later than the earlier of: (1) ninety (90) days after such individual's coverage commencement date under the Plan; or (2) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in subparagraph (d) of this Section.

(b) Employer Notice to Plan Administrator. The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's: (1) death; (2) termination of employment (other than gross misconduct); (3) reduction in hours; or (4) entitlement to Medicare benefits, within thirty (30) days after the date of the Qualifying Event.

(c) Covered Employee/Qualified Beneficiary Notice to Plan Administrator. The Covered Employee or Qualified Beneficiary must notify the Plan Administrator or its designee of: (1) a divorce or legal separation of the Covered Employee from the Covered Employee's spouse, as applicable; (2) a dependent ceasing to be a dependent under

the eligibility requirements of the Plan; or (3) a second Qualifying Event. Notification must occur as soon as possible, and for events under (1), (2) or (3) above, such notice must occur not later than sixty (60) days after the later of: (1) the date of such Qualifying Event; (2) the date that the Qualified Beneficiary loses or would lose coverage due to such Qualifying Event; or (3) the date on which the Qualified Beneficiary is informed, via the Plan's summary or the general COBRA notice, of the Qualified Beneficiary's obligation to provide such notice and the Plan procedures for providing such notice.

The Covered Employee, Qualified Beneficiary, or a representative acting on behalf of the Covered Employee or Qualified Beneficiary, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage.

The Plan shall establish reasonable procedures for the furnishing of the notice described above and shall publish such procedures in the Plan's summary. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of continuation coverage.

(d) Plan Administrator Notice to Qualified Beneficiary. Upon receipt of a notice of Qualifying Event under subsections (b) or (c), the Plan Administrator, or its designee, shall provide to each Qualified Beneficiary notice of their right to elect continuation coverage, no later than fourteen (14) days after the date on which the Plan Administrator, or its designee, received notice of these Qualifying Events. Any notification to a Qualified Beneficiary who is the spouse of the Covered Employee shall be treated as a notification to all other Qualified Beneficiaries residing with such spouse at the time such notification is made.

(e) Unavailability of Coverage. If the Plan Administrator, or its designee, receives a notice of an applicable Qualifying Event under subsection (c), and determines that the person is not entitled to continuation coverage, the Plan Administrator shall notify the person with an explanation as to why such coverage is not available within the time frame designated under subsection (d) above.

(f) Notice of Termination of Coverage. The Plan Administrator, or its designee, shall provide notice to each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such Qualifying Event as soon as practicable following the Plan Administrator's determination that continuation coverage should terminate.

(g) Use of a Single Notice. Notices required under subsections (d), (e), and (f) must be provided to each Qualified Beneficiary or individual; however, (1) a single notice can be provided to the Covered Employee and the Covered Employee's spouse if the Covered Employee spouse resides with the Covered Employee, and/or (2) a single notice can be provided to the Covered Employee, or the Covered Employee's spouse for a dependent child of the Covered Employee, if the dependent child resides with the Covered Employee or the Covered Employee's spouse (as applicable).

B6.8 Continuation Health Benefits Provided

The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the Health Care FSA under the Plan to similarly situated persons covered by the Plan with respect to whom a Qualifying Event has not occurred. If coverage is modified under the Health Care FSA under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are Qualified Beneficiaries under the Flexible Spending Account under the Plan. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an open enrollment period during which similarly situated active employees may choose to be covered under the Health Care FSA of the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

B6.9 Bankruptcy Proceedings

Special continuation coverage provisions apply in the event of bankruptcy of the Employer. Notwithstanding any of the preceding Sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of coverage occurs with respect to a Covered Employee who had retired on or before the date of the loss or substantial elimination of coverage (and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary under the Plan as a spouse, dependent child, or surviving spouse of a Covered Employee) within one (1) year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage shall be provided under the Health Care FSA of the Plan to the extent required under Code Section 4980B.

APPENDIX C

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION C1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Dependent Care Flexible Spending Account (Dependent Care FSA) incorporates by reference all the provisions of the Plan.

C1.1 Establishment of Dependent Care Flexible Spending Account

(a) This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 for the reimbursement of employment-related dependent care expenses and shall be interpreted in a manner consistent with Code Section 129.

(b) Participants who elect to participate in this program may submit claims for the reimbursement of employment-related dependent care expenses. All such amounts shall be reimbursed under this Dependent Care FSA program.

C1.2 Report to Participants On or Before January 31 of Each Year

On or before January 31 of each year, the Plan Administrator or its designee shall furnish to each Participant who has received reimbursements under the Dependent Care FSA during the prior calendar year, a written statement showing the amount of all Dependent Care FSA during the prior calendar year, a written statement showing the amount of all Dependent Care FSA reimbursements paid to or on behalf of the participant during the prior calendar year. Pursuant to Internal Revenue Service guidance, this written statement requirement may be satisfied, at the discretion of the Plan Administrator, by reporting the amount of Dependent Care FSA reimbursements on Form W-2.

SECTION C2
DEFINITIONS

Definitions in the Plan apply to this Dependent Care FSA, with the following additions:

C2.1 Dependent

“Dependent” means a "qualifying individual," as defined in Code Section 21(b).

C2.2 Dependent Care Service Provider

“Dependent Care Service Provider” means a person who provides care or other dependent care services, which qualify for the federal tax credit under Code Section 21, but shall not include: (a) a dependent care center (as defined in Code Section 21(b)(2)(D)) unless the requirements of Code Section 21(b)(2)(C) are satisfied; or (b) a related individual as described in Code Section 129(c).

C2.3 Qualifying Dependent Care Expenses

“Qualifying Dependent Care Expenses” means any dependent care expenses incurred by a Participant for dependent care services which qualify for the federal tax credit under

Code Section 21, and which have been incurred by or on behalf of a Participant, or Dependent, during a Period of Coverage. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

SECTION C3
BENEFITS

C3.1 Maximum Contribution

For a calendar year, Dependent Care FSA Contributions, combined with any other dependent care assistance received through an employment-related plan by the Participant, or his or her spouse, may not exceed the lesser of:

(a) $5,000 ($2,500 if the Participant is married and files a federal income tax return for the calendar year separately from his or her spouse); or

(b) The Participant's actual or deemed Earned Income, as defined in Code Section 32(c)(2), after all reductions in Compensation including the reduction related to participation in the Dependent Care Flexible Spending Account; or

(c) The Earned Income of the Participant's spouse, if the Participant is married. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of care for him or herself, such spouse shall be deemed to have earned income of not less than $250 per month if the Eligible Employee has one Dependent, and $500 per month if the Eligible Employee has two or more Dependents.

C3.2 Marital Status Determination

The determination as to the marital status of a Participant shall be made as of the close of the Plan Year.

C3.3 No Uniform Benefit

The Maximum Contribution elected by the Participant under the Dependent Care FSA shall not be available at all times during the Period of Coverage. Instead, at any time during the Period of Coverage, only the amount of the actual Contributions shall be available for reimbursement.

C3.4 Minimum Contribution

The Minimum Contribution shall be no less than $10 per pay period for a Participant during the Period of Coverage.

C3.5 Dependent Care Flexible Spending Account

The Plan Administrator shall establish a Dependent Care Flexible Spending for each Participant who elects to participate in the Dependent Care FSA program.

C3.6 Forfeitures

The amount in a Participant's Dependent Care FSA as of the end of any Plan year, and after the processing of all claims for such Plan Year, shall be forfeited and may be used as described in the Plan provisions related to Experience Gains in Section 7.5. In such event, the Participant shall have no further claim to such amount for any reason.

SECTION C4
CLAIMS DEADLINE

Claims under the Dependent Care FSA must be submitted pursuant to procedures established by the Plan Administrator, or its delegate, no later than March 31 following the close of the Plan Year in which the costs were incurred. Claims must be supported by documentation requested by the Plan Administrator.

SECTION C5
TERMINATION OF PARTICIPATION

C5.1 Termination of Participation

Participation in this Dependent Care FSA shall terminate on the earliest of:

(a) The date of termination of the Plan, unless otherwise communicated to Participants;

(b) The date on which the Participant fails to be an Eligible Employee;

(c) The date on which the Participant fails to make any required FSA contribution; or

(d) The end of the Plan Year.

APPENDIX D

FLEXIBLE CREDITS BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

FOR

CERTAIN "FLEXIBLE BENEFITS ELIGIBLE EMPLOYEES"

SECTION D1
GENERAL

Except to the extent provided otherwise in this Appendix, or in the Plan, the Flexible Credits Benefit Component incorporates by reference all the provisions of the Plan.

SECTION D2
DEFINITIONS

Definitions in the Plan apply to this Flexible Credits Benefit Component with the following additions:

D2.1 Flexible Credits

"Flexible Credits" means the dollar value a Flexible Credits Eligible Employee is allocated in credits in lieu of dependent coverage subsidized by the Employer to be applied to eligible Pre-Tax Benefit Options.

D2.2 Flexible Credits Eligible Employee

A "Flexible Credits Eligible Employee" is an Employee who

(a) is eligible for Municipal Executive Association benefits pursuant to an applicable Memorandum of Understanding; or

(b) is an unrepresented Employee who is determined from time to time by the City and County of San Francisco Department of Human Resources, or the Human Resources Department of the Superior Court, County of San Francisco, to be eligible for Municipal Executive Association (MEA) benefits.

D2.3 Pre-Tax Benefit Options

"Pre-Tax Benefit Options" means the pre-tax benefit options permitted under Code section 125 and available under this Plan for election by a Flexible Credits Eligible Employee using Flexible Credits.

SECTION D3
ELIGIBILITY AND PARTICIPATION

Flexible Benefits Eligible Employees shall be eligible to participate in this Flexible Credits Benefit Component.

SECTION D4
CLAIMS DEADLINE

Claims for Flexible Credits must be submitted pursuant to procedures established by the Plan Administrator, or its delegate, and no later than March 31 following the close of the Plan Year in which the costs were incurred. Claims must be supported by documentation requested by the Plan Administrator.

SECTION D5
BENEFITS

D5.1 Plan Benefits

(a) Flexible Credits shall be allocated as determined by the Flexible Benefits Eligible Employee and applied to eligible Pre-Tax or Post-Tax Benefit Options.

(b) Pre-Tax and Post-Tax Benefit Options may be established, and announced from time to time, by the Employer without formal written amendment of this Plan document. The Pre-Tax Benefit Options are as provided in Appendix E.

D5.2 Dollar Value of Flexible Credits

(a) The total annual dollar value of the Flexible Credits shall be established, and announced from time to time, by the Employer without formal written amendment of this Plan document.

(b) The Plan Year 2021~~0~~ dollar value of the Flexible Credits is as follows:

i) All City and County of San Francisco Flexible Credit Eligible Employees have the following amounts of Flexible Credits available to purchase from the Pre-Tax Benefits Options as set forth in Section in D.5: $ 373.04~~352.86~~ in credits bi-weekly for a medically-single employee or an employee who waives medical coverage; $ 430.43~~407.14~~ in credits bi-weekly for an employee with one dependent; $ 737.79~~697.93~~ in credits bi-weekly for an employee with two or more dependents who selects Kaiser; $ 866.02~~815.08~~ in credits bi-weekly for an employee with two or more dependents who selects Blue Shield Trio; or $999.23~~964.93~~ in credits biweekly for an employee with two or more dependents who selects Blue Shield Access+ or City Health Plan.

ii) Superior Court Flexible Credit Eligible Employees: $1,231.00~~1,137.00~~ in credits bi-weekly to purchase from the Pre-Tax Benefit Options listed in D.5.1.

D5.3 Unallocated Flexible Credits

The amount of any Flexible Credits remaining (unallocated) to either pre-tax or post-tax benefits will be paid to the employee as taxable earnings each pay period.

APPENDIX E

HEALTH SERVICE SYSTEM BENEFIT PROGRAMS
As of January 1, 2021~~0~~

The following are the Health Service System Benefit Programs available as of January 1, 2018. Eligibility for a particular Health Service System Benefit Program shall be as determined from time to time by the Employer without written amendment to this Plan~~.~~

Pre-Tax Benefit Program	Admin By	Funding	Insurer or Third Party Administrator	Policy or Contract Number
Pre-Tax Benefit Options				
Pre-Tax Medical				
Blue Shield of California Access + HMO	HSS	Flex-Funded	Blue Shield of California HMO	W0051448
Blue Shield of California Trio HMO	HSS	Flex-Funded	Blue Shield of California HMO	W0051448
Kaiser HMO	HSS	Insured	Kaiser Permanente	888
City Health Plan	HSS	Self-funded	United Healthcare	752103
Pre-Tax Dental				
Delta Dental Preferred In-Network PPO Delta Premier & OON PPO Providers	HSS	Self-Funded	Delta Dental of California	9502-0003
DeltaCare USA DMO	HSS	Insured	Delta Dental of California	01797-0001
United Healthcare Dental DMO	HSS	Insured	United Healthcare	275550
Pre-Tax Vision				
Vision Service Basic Plan	HSS	Insured	Vision Service Plan	12145878
Vision Service Premier Plan	HSS	Insured	Vision Service Plan	12145878
Pre-Tax Health Flexible Spending Account (FSA)				
Health Flexible Spending Account	HSS	Self-funded	P&A	
Pre-Tax Dependent Care Flexible Spending Account (FSA)				
Dependent Care FSA	HSS	Self-funded	P&A	
Pre-Tax Cancer Insurance				
Cancer Insurance – CAF only	HSS	Insured	EBS-Allstate	D-5895CA-2
Cancer Initial Diagnosis Rider – CAF only	HSS	Insured	EBS-Allstate (rider to Cancer)	D-5901CA-2
Pre-Tax Critical Illness				
Heart/Stroke Insurance – CAF only	HSS	Insured	EBS-Allstate	D-5900CA-2
Intensive Care Rider – CAF only	HSS	Insured	EBS-Allstate (rider Heart/Stroke)	D-5898CA
Pre-Tax Accident Insurance				
Accident Insurance – CAF only	HSS	Insured	EBS-Allstate	SWD9539CA
Sickness Disability Rider – CAF only	HSS	Insured	EBS-Allstate (rider to Accident)	D-4669CA
Pre-Tax Long Term Disability Insurance				
Long Term Disability Insurance – MEA	HSS	Insured	The Hartford(100% Employer Paid)	GP-839201

Long Term Disability Insurance – MAA	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Long Term Disability – SEIU, et al.	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Pre-Tax (Group Term Life Insurance				
Life Insurance $50,000 – Local 21, Auto. Mach., Local 1414, Craft Coalition, Deputy Probation Officers, Plumbers, Local 38	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Life Insurance $50,000 – TWU Locals 200 & 250-A	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Life Insurance $50,000 – SEIU,Courts et al	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Life Insurance $~~50~~100,000 – MEA	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Life Insurance $125,000 – Court IFPTE	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Life Insurance $150,000 – MAA	HSS	Insured	The Hartford (100% Employer Paid)	GP-839201
Post-Tax Benefit Program	**Admin By**	**Funding**	**Insurer or Third Party Administrator**	**Policy or Contract Number**
Post-Tax Benefit Options				
Post-Tax Universal Life Insurance				
Post-Tax Critical Illness				
Critical Illness	HSS	Insured	EBS - Voya	69674-9 CCI
Critical Illness	HSS	Insured	EBS – Met Life	229012
Post-Tax Short Term Disability				
Short Term Disability	HSS	Insured	EBS-Voya (Employee Paid)	01758
Short Term Disability	HSS	Insured	EBS-Abacus	AS0010701
Post-Tax Long Term Care Insurance				
Long Term Care Insurance – CAF only	HSS	Insured	EBS-TransAmerica (Employee Paid)	TLC-1-FPCA
Post-Tax Pet Insurance				
Pet Insurance	HSS	Insured	EBS-PetsBest	Unique to each member
Post-Tax Pre-Paid Legal				
Pre-Paid Legal	HSS	Voluntary	EBS - Pre-Paid Legal Services Inc.	43909
Post-Tax Group Supplemental Life Insurance				
Life Insurance up to $500,000	HSS	Voluntary	The Hartford (Employee Paid)	GP-839201
Post-Tax Identity Theft Protection				
~~Identity Theft Protection~~	~~HSS~~	~~Voluntary~~	~~EBS - LifeLock~~	
Identity Theft Protection	HSS	Voluntary	EBS – EBS-Allstate	5105
Post—Tax Accident Insurance				
Accident Insurance	HSS	Insured	EBS-Voya	69674-9 CAC
Accident Insurance	HSS	Insured	EBS-MetLife	229012

CAF only - means that this benefit is only offered by HSS to employees with the MEA cafeteria plan benefit options.

APPENDIX F

HEALTH SERVICE SYSTEM RULES

The Health Service System Rules, as approved by the Health Service System Board and posted on http://www.sfhss.org/ as they may be amended from time to time, are hereby incorporated by reference without further amendment to this document.