Human Resources & Development
COUNTY OF TULARE
AGENDA ITEM

AGENDA DATE: January 15, 2008

Public Hearing Required	Yes ☐	No x	N/A ☐
Scheduled Public Hearing w/Clerk	Yes ☐	No ☐	N/A x
Published Notice Required	Yes ☐	No x	N/A ☐
Advertised Published Notice	Yes ☐	No ☐	N/A x
Meet & Confer Required	Yes ☐	No x	N/A ☐
Electronic file(s) has been sent	Yes x	No ☐	N/A ☐
Budget Transfer (Aud 308) attached	Yes ☐	No ☐	N/A x
Personnel Resolution attached	Yes ☐	No ☐	N/A x
Resolution, Ordinance or Agreements are attached and signature line for Chairman is marked with tab(s)/flag(s)	Yes x	No ☐	N/A ☐

CONTACT PERSON: Tim Huntley PHONE: 733-6266

SUBJECT: Tulare County Flexible Benefits Plan

REQUEST(S):

That the Board of Supervisors:

Ratify and adopt the updated Tulare County Flexible Benefits Plan as a cafeteria plan under Section 125 of the Internal Revenue Code to provide benefits under the Plan are eligible to be excluded from Federal income tax.

Authorize the Chairman to sign the plan documents pending review and approval by County Counsel.

SUMMARY:

In 1996, as provided for under Section 125 of the Internal Revenue Code of 1986, Tulare County created the Tulare County Flexible Benefits Plan. This Plan allows employees to elect to pay for specified employer-offered benefits on a pre-tax basis or, in the alternative, to receive cash compensation. The amount of the cash compensation is as provided for in the agreed-upon Memoranda of Understanding between the County and the employee bargaining units, and for those employees who are unrepresented, as determined by the Board of Supervisors. Benefits included in the Tulare County Flexible Benefits Plan include: health insurance (medical, dental, and vision coverage); employer-mandated insurance (life and, for certain designated employees, long-term disability insurance); flexible spending accounts (health care and dependent care reimbursement); and qualified

supplemental benefits.

The Tulare County Flexible Benefits Plan document establishes the administrative policies that govern the Plan. Included in the document are:

1) the plan year on which the Plan operates;
2) eligibility rules regarding participation;
3) procedures governing participant elections under the Plan including conditions under which a change to an irrevocable election can be made;
4) source of contributions, maximum contribution amount(s), participant accounts, and payment of benefits; and
5) general provisions governing the Plan inclusive of Plan administration.

The updated version of the Tulare County Flexible Benefits Plan document 1) lists the provisions under which the Plan will be administered in 2008; 2) links eligibility to the specific benefit in which an employee is seeking to be enrolled; 3) addresses impact of the Family Medical Leave Act (FMLA) on continued eligibility; 4) adds and defines conditions under which an election change is permitted; and 5) reflects the current Medical Flexible Spending Account limit of $2500. The updates to the Plan document are intended to ensure that the document conforms to law.

FISCAL IMPACT/FINANCING:

There is no additional financial impact. This program has been in place since 1996 and both the County and the employees have benefited from lower payroll-related taxes.

LINKAGE TO THE COUNTY OF TULARE STRATEGIC BUSINESS PLAN:

The County's five-year strategic plan includes *Strategic Initiative 4, Organizational Performance – Continuously improve organizational effectiveness and fiscal stability*. Ratification and adoption of the Tulare County Flexible Benefits Plan will help to ensure that County 1) remains fiscally sound by not incurring additional payroll-related taxes, and 2) provides a competitive compensation package which assists us in recruiting and retaining employees, the cornerstone of an effective organization.

SUBJECT: Tulare County Flexible Benefits Plan
DATE: January 15, 2008

ALTERNATIVES:

The Board could choose to not ratify and adopt the updated Tulare County Flexible Benefits Plan; however, this is not recommended as it would mean that the County could no longer offer its benefits on a pre-tax basis. Both the County and employees would be subject to higher payroll-related taxes and, for employees, this means that the health insurance will be even less affordable. The County would also have to meet and confer with employees on the impact of this change which likely would result in reduced employee morale and increased turnover. It could also impede our ability to recruit experienced staff. Additionally, the Auditor's office would have to recalculate employer and employee tax obligations for any earnings paid in 2008.

INVOLVEMENT OF OTHER DEPARTMENTS OR AGENCIES:

County Counsel

ADMINISTRATIVE SIGN-OFF:

Tim Huntley
Human Resources Director

Cc: Auditor/Controller
County Counsel
County Administrative Office (2)

Attachment(s)

Attachment A – Tulare County Flexible Benefits Plan
Attachment B – Tulare County Dependent Daycare Plan
Attachment C – Tulare County Medical Reimbursement Plan
Attachment D – Tulare County Flexible Benefits Plan Notice of Privacy Practices
Attachment E – Tulare County Flexible Benefits Plan Summary Plan Description

BEFORE THE BOARD OF SUPERVISORS
COUNTY OF TULARE, STATE OF CALIFORNIA

IN THE MATTER OF	)	
The Tulare County	)	**RESOLUTION NO. _____**
Flexible Benefit Plan	)	**AGREEMENT NO. _____**

UPON MOTION OF SUPERVISOR _____, SECONDED BY SUPERVISOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF SUPERVISORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST: JEAN ROUSSEAU
COUNTY ADMINISTRATIVE OFFICER
CLERK, BOARD OF SUPERVISORS

BY: _____
Deputy Clerk

* * * * * * * * * * * * * * * * * * *

Ratified and adopted the updated Tulare County Flexible Benefits Plan as a cafeteria plan under Section 125 of the Internal Revenue Code to provide benefits under the Plan are eligible to be excluded from Federal income tax.

Authorized the Chairman to sign the plan documents pending review and approval by County Counsel.

Attachment A

TULARE COUNTY
FLEXIBLE BENEFITS PLAN

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ARTICLE VII - GENERAL PROVISIONS

TULARE COUNTY
FLEXIBLE BENEFITS PLAN

ARTICLE I

INTRODUCTION

1.1 Creation and Title. The Employer hereby creates a cafeteria plan under the terms and conditions set forth in this document. The Plan is to be known as Tulare County Flexible Benefits Plan.

1.2 Effective Date. The provisions of the Plan shall be effective as of January 1st, 2008.

1.3 Purpose. The purpose of the Plan is to allow employees to select among cash compensation and certain nontaxable benefits, namely coverage under one or more benefits programs maintained by the Employer. The Employer intends that the Plan qualify as a cafeteria plan under Section 125 of the Code, and that the benefits provided under the Plan be eligible for exclusion from Federal income tax.

ARTICLE II

DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 "Benefit Entry Date" means for each Eligible Employee the day that the Employee becomes eligible to participate in each of the Plan's Benefits. If the Plan does not have different eligibility requirements for each benefit, the Benefit Entry Date will be the same as the Plan Entry Date.

2.2 "Benefits" mean cash and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including, but not limited to, health insurance, group term life insurance, disability insurance, qualified supplemental benefits, medical reimbursement and dependent care reimbursement.

2.3 "Benefits Accounts" mean the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

2.4 "Benefits Enrollment Form" means the form or forms, including a Salary Reduction Agreement, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.

2.5 "Change in Status"

(a) With regard to the election to participate in the Plan and elections for Medical Flexible Spending Account benefits, Change in Status shall mean the marriage or divorce of the Participant; the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment of the Participant or Participant's Spouse; change in the Participant's residence (to the extent eligibility for participation in a particular plan is subject to geographic limitations); the Participant beginning or ending adoption proceedings, or; Medicare or Medicaid entitlement.

(b) With regard to the election to participate in the Plan and elections for all other Plan Benefits, Change in Status shall mean the marriage or divorce of the Participant; the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment of the Participant or Participant's Spouse; change in the Participant's residence (to the extent eligibility for participation in a particular plan is subject to geographic limitations) ; the Participant beginning or ending adoption proceedings; automatic changes upon cost increases or decreases;; significant curtailment of coverage; addition or elimination of similar benefit package option allowing (prohibiting) employees that previously opted out of other benefits to make an election change; change in coverage under employer plan of spouse or dependent; FMLA leaves; HIPAA special enrollment rights; a COBRA qualifying event; a judgment, decree or order, or; Medicare or Medicaid entitlement.

2.6 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.7 "Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

2.8 "Dependent" means an individual who is a dependent within the meaning of Section 152(a) without regard to 152(b)(1, (b)(2), and (d)(1)(B) thereof of the Code of a Participant or a former Participant in the Plan.

2.9 "Effective Date" shall be January 1st, 2008.

2.10 "Eligible Employee" means an Employee, as defined in Section 2.11 below, who is eligible to participate in the Employer's health care program, and shall include employees who regularly work at least 40 hours per pay period, except for: (1) Employees who are Non-Resident Aliens (within the meaning of section 7701(b)(1)(B) of the Code deriving no earned income (within the meaning of section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3) of the Code), and (2) Employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership

2.11 "Employee" means a person who is currently or hereafter employed by the Employer Excluding individuals who are not contemporaneously classified as Employees of the Employer for purposes of the Employer's payroll system (including, without limitation, individuals employed by temporary help firms, technical help firms, staffing firms, employee leasing firms, professional employer organizations or other staffing firms whether or not deemed to be "common law" Employees or "Leased Employees" within the meaning of section 414(n) (o) of the Code) are not considered to be Eligible Employees of the Employer and shall not be eligible to participate in the Plan. In the event any such individuals are reclassified as Employees for any purpose, including without limitation, common law or statutory employees, by any action of any third party, including, without limitation, any government agency, or as a result of any private lawsuit, action, or administrative proceeding, such individuals shall notwithstanding such reclassification, remain ineligible for participation hereunder. Notwithstanding foregoing, the exclusive means for individuals who are not contemporaneously classified as an Employee of the Employer on the Employer's payroll system to become eligible to participate in this Plan is through an amendment to this Plan, duly executed by the Employer, which specifically renders such individuals eligible for participation hereunder.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision shall be final, binding and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

2.12 "Employer" means Tulare County.

2.13 "Participant" means any Employee who has met the eligibility requirements of Section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Benefits Enrollment Form.

2.14 "Plan" means Tulare County Flexible Benefits Plan, as described herein.

2.15 "Plan Administrator" means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan.

2.16 "Plan Entry Date" means for each Eligible Employee, the day that the Employee becomes eligible to participate in the Plan.

2.17 "Plan Year" means the 12-consecutive month period beginning on January 1st and ending on December 31st.

2.18 "Salary Reduction Agreement" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of making contributions toward Benefits under the Plan.

2.19 "Spouse" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

2.20 "Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status.

ARTICLE III

PARTICIPATION

3.1 Eligibility. Each Employee, as defined in section 2.10 above, shall be eligible to participate in the Plan as follows:

- Tulare County Employees (except for members of the Tulare County Corrections Association and the Tulare County Deputy Sheriffs' Association) 1st day of the month following 30 calendar days of employment.
- Tulare County Corrections Association: 1st day of month following 60 calendar days of employment with the Probation Department.
  Tulare County Deputy Sheriffs' Association: 1st full day of regular service with the Sheriff's Department.

3.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrollment Form setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year or remaining portion of the Plan Year. As part of the Benefits Enrollment Form, the Participant shall also execute a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. The Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Form. Each new Benefits Enrollment Form shall specify the type and amount of Benefits to be made available to the Participant for the immediately following Plan Year or remaining portion of the Plan Year.

3.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) the date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 3.4;

(b) the date the Participant fails to make required contributions under the Plan;

(c) the end of the plan year the Participant ceases to be an Eligible Employee; or

(d) the date the Plan terminates.

3.4 Treatment of Rehired Employees. A Participant whose employment terminates and who is subsequently re-employed with less than 30 days separation of service will immediately rejoin the Plan with the same Benefit elections. Should the Participant return to service during the following Plan Year, the Participant would not be allowed to elect new Benefits prior to returning to service, unless the Employee should incur an applicable Change in Status.

A Participant whose employment terminates and who is subsequently re-employed with more than 29 days separation of service may immediately rejoin the Plan and may make new benefit elections. Any unused reimbursement Benefits Accounts balance prior to the initial separation of service date will be forfeited.

3.5 HIPAA Portability. Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Portability and Accountability Act of 1996("HIPAA") for coverage by an Accident or Health benefit

under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

3.6 COBRA Continuation Coverage. Under COBRA, this section 3.6 shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.7 Family Medical Leave Act. Under the FMLA, the provisions of this section 3.7 shall not be available to Eligible Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Eligible Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

Payment Options for coverage while on unpaid Family Medical Leave Act leave for group plans:

(a) Pre-pay before commencement of leave.

(b) Pay-as-you-go. Employees may pay their share of premium payments on a monthly basis in advance (subject to any grace period as approved by the employer), or under another schedule permitted under Department of Labor regulations.

The Employer shall not be required to continue the health coverage of an Employee who fails to make required premium payments while on FMLA leave. However, if the Employer chooses to continue the health coverage of an Employee who fails to make required premium payment while on FMLA leave, the Employer is entitled to recoup those payments after the Employee returns from FMLA leave.

An "Eligible Employee" is an Employee of a covered Employer who:

(1) Has been employed by the Employer for at least 12 months, and
(2) Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave, and
(3) Is employed at a worksite where 50 or more Employees are employed by the Employer within 75 miles of that worksite. (See Section 825.105(a) regarding Employees who work outside the U.S.)

The 12 months an Employee must have been employed by the Employer need not be consecutive months. If an Employee is maintained on the payroll for any part of a week, including any periods of paid or unpaid leave (sick, vacation) during which other benefits or compensation are provided by the Employer (e.g., workers' compensation, group health plan benefits, etc.), the week counts as a week of employment. For purposes of determining whether intermittent/occasional/casual employment qualifies as "at least 12 months," 52 weeks is deemed to be equal to 12 months.

Whether an Employee has worked the minimum 1,250 hours of service is determined according to the principles established under the Fair Labor Standards Act (FLSA) for determining compensable hours of work (see [29 CFR 785]). The determining factor is the number of hours an Employee has worked for the Employer within the meaning of the FLSA. The determination is not limited by methods of recordkeeping, or by compensation agreements that do not accurately reflect all of the hours an Employee has worked for or been in service to the Employer. Any accurate accounting of actual hours worked under FLSA's principles may be used. In the event the Employer does not maintain an accurate record of hours worked by an Employee, including for Employees who are exempt from FLSA's requirement that a record be kept of their hours worked (e.g., bona fide executive, administrative, and professional employees as defined in FLSA Regulations, [29 CFR 541]), the Employer has the burden of showing that the Employee has not worked the requisite hours. In the event the Employer is unable to meet this burden the Employee is deemed to have met this test. See also 29 CFR Section 825.500(F). For this purpose, full-time teachers (see 29 CFR Section 825.800 for definition) of an elementary or secondary school system, or institution of higher education, or other educational establishment or institution are deemed to meet the 1,250 hour test. An Employer must be able to clearly demonstrate that such an Employee did not work 1,250 hours during the previous 12 months in order to claim that the Employee is not "Eligible" for FMLA leave.

The determinations of whether an Employee has worked for the Employer for at least 1,250 hours in the past 12 months and has been employed by the Employer for a total of at least 12 months must be made as of the date leave commences. If an Employee notifies the Employer of need for FMLA leave before the Employee meets these eligibility criteria, the Employer must either confirm the Employee's eligibility based upon a projection that the Employee will be eligible on the date leave would commence or must advise the Employee when the eligibility requirement is met. If the Employer confirms eligibility at the time the notice for leave is received, the Employer may not subsequently challenge the Employee's eligibility. In the latter case, if the Employer does not advise the Employee whether the Employee is eligible as soon as practicable (i.e., two business days absent extenuating circumstances) after the date Employee eligibility is determined, the Employee will have satisfied the notice requirements and the notice of leave is considered current and outstanding until the Employer does advise. If the Employer fails to advise the Employee whether the Employee is eligible prior to the date the requested leave is to commence, the Employee will be deemed eligible. The Employer may not, then, deny the leave. Where the Employee does not give notice of the need for leave more than two business days prior to commencing leave, the Employee will be deemed to be eligible if the Employer fails to advise the Employee that the Employee is not eligible within two business days of receiving the Employee's notice.

The period prior to the FMLA's effective date must be considered in determining Employee's eligibility.

Whether 50 Employees are employed within 75 miles to ascertain an employee's eligibility for FMLA benefits is determined when the Employee gives notice of the need for leave. Whether the leave is to be taken at one time or on an intermittent or reduced leave schedule basis, once an Employee is determined eligible in response to that notice of the need for leave, the Employee's eligibility is not affected by any subsequent change in the number of Employees employed at or within 75 miles of the Employee's worksite, for that specific notice of the need for leave. Similarly, an Employer may not terminate employee leave that has already started if the Employee-count drops below 50. For example, if an Employer employs 60 Employees in August, but expects that the number of Employees will drop to 40 in December, the Employer must grant FMLA benefits to an otherwise Eligible Employee who gives notice of the need for leave in August for a period of leave to begin in December.

ARTICLE IV

CONTRIBUTIONS

4.1 Source of Contributions. The Employer shall contribute amounts deemed necessary to meet its obligations under the Plan. Contributions to the Plan for the Plan Year shall be limited to the amounts determined by the Benefits Enrollment Form entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in such accounts or funds as the Employer deems appropriate.

4.2 Change in Participant's Benefits Enrollment. No Participant in the Plan shall be allowed to alter or discontinue the Participant's elected Benefits under the Plan during a Plan Year except when due to and consistent with a Change in Status.

Upon the occurrence of a Change in Status, the Participant may file a new Benefits Enrollment form, which will serve to revoke the Participant's previous Benefits Enrollment Form. The new Benefits Enrollment Form, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively and apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Form.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment period. With respect to any other change in election, the Plan Administrator shall determine if the new Benefits Enrollment Form has been timely submitted consistent with the nature of the Change in Status.

The Participant's Benefits Enrollment Form for a given Plan Year shall terminate and Benefits under the Plan shall cease as of the last day of the Plan Year during which a Participant is no longer eligible to participate under the terms of this Plan.

4.3 Increases or Decreases in Premiums. Should a third party benefit provider, such as an Insurance Company, increase or decrease premiums for any health benefits being offered under this Plan during the Plan Year, any Participant participating in such benefit shall have his contributions increased or decreased automatically in an amount sufficient to pay for such increase or decrease. However, in the case of an increase in premium, if there is a similar benefit offered under the Plan at the time of said increase, the Participant may select such similar benefit rather than pay the increase.

Notwithstanding anything to the contrary in the preceding paragraph, the Employer reserves the right to reduce the Participants' share of any Premiums and increase the Employer's share by a like amount. The duration of this "Premium Holiday" is at the Employer's discretion. The Employer will notify the Participants prior to ceasing the "Premium Holiday."

The Employer reserves the right to increase the Participants' share of any Premiums and decrease the Employer's share by a like amount. The duration of this is at the Employer's discretion. The Employer will notify Participants prior to raising the Participants' obligations. As this is considered to be temporary, Participants will not be considered to have incurred a Change in Status should the Employer invoke this option.

4.4 Maximum Contribution. The Maximum Contribution any individual can make under this Plan is an amount equal to the sum of the costs for each of the highest cost premium-type Benefit Options offered under the Plan in each Benefit Category plus the sum of the deferrals made to Reimbursement-type Benefit programs under this Plan. The term "Benefit Option" refers to any category of Benefits offered under this Cafeteria Plan in which the Participant has the opportunity to choose one benefit from several different Options in that category. The term "Benefit Category" refers to any category of Benefits offered under this Plan and may include (but is not limited to) Health Insurance, Group Term Life Insurance or Disability Insurance.

4.5 Nondiscrimination. The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of the Code. The Plan

Administrator may take such actions as excluding certain highly compensated individuals from participation in the Plan or limiting the contributions made with respect to certain highly compensated participants if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

ARTICLE V

PARTICIPANTS' ACCOUNTS AND PAYMENT OF BENEFITS

5.1 Participants' Benefit Accounts. The Plan Administrator shall establish separate Benefits Accounts based on the Benefits selections made by each Participant. Contributions shall be credited to the proper Benefits Accounts of each Participant. Each Benefits Account shall be designated as a "Premium Account" or as a "Reimbursement Account".

5.2 Premium Account. A "Premium Account" is an account established with the intent of paying for premium-type Benefits pursuant to an insurance policy issued by an insurance company, or a contract with a health maintenance or preferred provider organization to provide medical, dental, vision, psychological or psychiatric, prescription drugs, group-term life insurance, disability insurance, or other qualified benefits under Section 125.

5.3 Reimbursement Account. A "Reimbursement Account" is an account established with the intent of providing reimbursement of allowable expenses pursuant to a medical or dependent care reimbursement plan offered by the Employer.

5.4 Payment of Benefits. The Plan Administrator shall pay the Benefits authorized under the Plan other than insurance benefits administered by a third-party benefit provider. Payment shall be made by the Employer, (or the designated Plan Administrator), in a timely manner upon receipt of a Premium Notice from the Benefit Provider providing such benefit. In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse,

(c) Family member held responsible for payment of deceased's medical bills,

(d) Spouse of dependent with COBRA continuation rights.

5.5 Qualified Supplemental Benefits. Accident, Disability, Cancer and Medical Gap Plan

ARTICLE VI

PLAN ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

6.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent or designated beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 125 of the Code.

6.3 Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions of Section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake

of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures.

If requested in writing, and within 30 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim. The Employer's representative, the Human Resources Director or designee, shall serve as the Plan Administrator for the purpose of conducting the requested review and confirming, modifying, or overruling the initial decision regarding the claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

6.8 Indemnity. The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any sole proprietor, member, partner, officer or director of the Employer, designated by the Employer or the Plan Administrator who has been employed, hired or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

ARTICLE VII

GENERAL PROVISIONS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or designated beneficiary was or might have been entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Section 125 of the Code or any other provision of the Code applicable to the Plan.

7.2 Nonassignability. Any benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and designated beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

7.3 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

7.4 Participant Litigation. In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

7.5 Addresses, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.6 Required Information. Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.7 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.8 Applicable Law. The Plan shall be construed under the laws of the State of California, to the extent not preempted by any Federal law.

Executed this _____ day of _____, _____.

Employer: TULARE COUNTY

_____

Attachment B

TULARE COUNTY
DEPDENDENT DAYCARE PLAN

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TULARE COUNTY
DEPDENDENT DAYCARE PLAN

ARTICLE I

INTRODUCTION

1.1 Creation and Title. The Employer hereby creates a welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as Tulare County Depdendent Daycare Plan.

1.2 Effective Date. The provisions of the Plan shall be effective as of January 1st, 2008.

1.3. Purpose. The purpose of the Plan is to provide reimbursement for certain dependent care expenses of Participants not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualifies as a dependent care assistance plan under Section 129(d) of the Code, and that the benefits provided under the Plan be eligible for exclusion from Participants' income under Section 129 of the Code.

ARTICLE II

DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 "Agreement to Participate" means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Dependent Care Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Dependent Care Expenses.

2.2 "Benefit Entry Date" means for each Eligible Employee the day that the Employee becomes eligible to participate in each of the Plan's Benefits. If the Plan does not have different eligibility requirements for each benefit, the Benefit Entry Date will be the same as the Plan Entry Date.

2.3 "Cafeteria Plan" means Tulare County Flexible Benefits Plan.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.5 "Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(a)(8), 402(h), 403(b) or 457(b) of the Code.

2.6 "Dependent" means an individual who is a dependent within the meaning of Section 152(a) without regard to 152(b)(1, (b)(2), and (d)(1)(B) thereof of the Code of a Participant in the Plan.

2.7 "Dependent Care Expenses" means expenses incurred by a Participant for the care of a Dependent or Spouse of the Participant or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Code.

2.8 "Dependent Care Reimbursement Benefits" means, for any Plan Year, the amount available to a Participant as benefits in the form of reimbursements of Dependent Care Expenses.

2.9 "Dependent Care Reimbursement Benefits Account" means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Dependent Care Expenses shall be paid.

2.10 "Effective Date" shall be January 1st, 2008.

2.11 "Eligible Employee" means an Employee, as defined in Section 2.12 below, who is eligible to participate in the Employer's health care program, and shall include employees who regularly work at least 40 hours per pay period, except for: (1) Employees who are Non-Resident Aliens (within the meaning of section 7701(b)(1)(B) of the Code deriving no earned income (within the meaning of section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3) of the Code), and (2) Employees who are self-employed individuals as defined in section 401(c) of the Internal revenue Code (including sole proprietors and partners in a partnership).

2.12 "Employee" means a person who is currently or hereafter employed by the Employer,. Excluding individuals who are not contemporaneously classified as Employees of the Employer for purposes of the Employer's payroll system (including, without limitation, individuals employed by temporary help firms, technical help firms, staffing firms, employee leasing firms, professional employer organizations or other staffing firms whether or not deemed to be "common law" Employees or "Leased Employees" within the meaning of section 414(n) (o) of the Code) are not considered to be Eligible Employees of the Employer and shall not be eligible to participate in the Plan. In the event any such individuals are

reclassified as Employees for any purpose, including without limitation, common law or statutory employees, by any action of any third party, including, without limitation, any government agency, or as a result of any private lawsuit, action, or administrative proceeding, such individuals shall notwithstanding such reclassification, remain ineligible for participation hereunder. Notwithstanding foregoing, the exclusive means for individuals who are not contemporaneously classified as an Employee of the Employer on the Employer's payroll system to become eligible to participate in this Plan is through an amendment to this Plan, duly executed by the Employer, which specifically renders such individuals eligible for participation hereunder.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision shall be final, binding and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

2.13 "Employer" means Tulare County.

2.14 "Form" means both physical as well as electronic "forms" or "documents" unless specifically identified as a hard copy form or document.

2.15 "Participant" means any Employee who has met the eligibility requirements of Section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Agreement to Participate and Salary Reduction Agreement.

2.16 "Plan" means Tulare County Dependent Daycare Plan, as described herein.

2.17 "Plan Administrator" means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan.

2.18 "Plan Entry Date" means for each Eligible Employee, the day that the Employee becomes eligible to participate in the Plan.

2.19 "Plan Year" means the 12-consecutive month period beginning on January 1st and ending on December 31st.

2.20 "Salary Reduction Agreement" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Dependent Care Reimbursement Benefits under the Plan.

2.21 "Spouse" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

2.22 "Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status.

ARTICLE III

PARTICIPATION

3.1 Eligibility. Each Employee, as defined in section 2.11 above, shall be eligible to participate in the Plan as follows:

- Tulare County Employees (except for members of the Tulare County Corrections Association and the Tulare County Deputy Sheriffs' Association) 1st day of the month following 30 calendar days of employment.
- Tulare County Corrections Association: 1st day of month following 60 calendar days of employment with the Probation Department.
  Tulare County Deputy Sheriffs' Association: 1st full day of regular service with the Sheriff's Department.

3.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrollment Form setting forth the amount of Dependent Care Reimbursement Benefits to be made available to the Eligible Employee for the immediately following Plan Year or remaining portion of the Plan Year. The Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Form. Each such new agreement shall specify the amount to be made available to the Participant for the immediately following Plan Year or remaining portion of the Plan Year covered by the agreement.

3.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) the date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 3.4;

(b) the date the Participant fails to make required contributions under the Plan;

(c) the end of the plan year the Participant ceases to be an Eligible Employee; or

(d) the date the Plan terminates.

3.4 Treatment of Rehired Employees. A Participant whose employment terminates and who is subsequently re-employed with less than 30 days separation of service will immediately rejoin the Plan with the same Benefit elections. Should the Participant return to service during the following Plan Year, the Participant would not be allowed to elect new Benefits prior to returning to service, unless the Employee should incur an applicable Change in Status.

A Participant whose employment terminates and who is subsequently re-employed with more than 29 days separation of service may immediately rejoin the Plan and may make new benefit elections. Any unused reimbursement Benefits Accounts balance prior to the initial separation of service date will be forfeited.

ARTICLE IV

BENEFITS

4.1 Provision of Benefits. Benefits under the Plan shall take the form of reimbursement of Dependent Care Expenses incurred by a Participant, the Participant's Spouse and the Participant's Dependents during the Plan Year.

4.2 Amount of Reimbursement. A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Dependent Care Reimbursement Benefits. The amount of a Participant's Dependent Care Reimbursement Benefits shall be available during the Plan Year in accordance with the provisions of Section 5.2.

4.3 Change in Participant Election. A Participant may not change the amount of Dependent Care Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to a change in status in the Cafeteria Plan.

4.4 Nondiscriminatory Benefits. The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.5 Maximum Benefits. Notwithstanding any other provisions of this Plan, no Participant shall receive Dependent Care Reimbursement Benefits in excess of $5,000 (or $2,500 in the case of a married Participant filing a separate Federal income tax return) in a calendar year.

ARTICLE V

FUNDING AND PAYMENT OF BENEFITS

5.1 Funding. Contributions to the Plan for the Plan Year shall be limited to the amounts determined by the Salary Reduction Agreements entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

5.2 Participants' Accounts and Account Balances. The Plan Administrator shall establish a separate Dependent Care Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Dependent Care Reimbursement Benefits Account with the amount of Dependent Care Reimbursement Benefits to be made available to the Participant pursuant to the Agreement to Participate as those amounts are actually contributed to the Plan. The Plan Administrator shall charge a Participant's Dependent Care Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The amount of any reimbursement of Dependent Care Expenses may not exceed the balance of the Participant's Dependent Care Reimbursement Account at the time of the reimbursement. The Plan Administrator may also establish a minimum reimbursable amount below which reimbursements shall not be made during the Plan Year, but which must be made by the end of the Plan Year (including the period set forth in Section 5.4).

5.3 Payment of Benefits. Reimbursement shall only be made under the Plan on the basis of Dependent Care Expenses incurred by the Participant or the Participant's Spouse, as presented to the Plan Administrator on a written form specified by the Plan Administrator. It shall be the duty of the Plan Administrator to construe what are and what are not Dependent Care Expenses subject to reimbursement from a Participant's Dependent Care Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Dependent Care Expense subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Dependent Care Expense within a reasonable time. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

(a) the name of the person or persons for whom the expenses have been incurred;

(b) the nature of the expenses incurred;

(c) the date the expenses were incurred;

(d) the amount of the requested reimbursement; or

(e) that the expenses have not been otherwise paid through a program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Dependent Care Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse,

(c) Family member held responsible for payment of deceased's medical bills,

(d) Spouse of dependent with COBRA continuation rights.

5.4 Forfeiture of Benefits. A Participant forfeits any amount of Dependent Care Reimbursement Benefits under the Plan for a Plan Year if a claim for reimbursement is not provided to the Plan Administrator within 90 days after the last day of the Plan Year. Upon such forfeiture, the Participant's Dependent Care Reimbursement Benefits Account shall be reduced to zero. At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

5.5 Annual Report to Participants. On or before each January 31, the Plan Administrator shall provide a written statement to each Participant (or former Participant) of the amount of reimbursements of Dependent Care Expenses paid to the Participant (or former Participant) for the immediately preceding calendar year.

ARTICLE VI

PLAN ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

6.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 129 of the Code.

6.3 Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions of Section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake

of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 60 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures.

If requested in writing, and within 60 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim. The Employer's representative, the Human Resources Director or designee, shall serve as the Plan Administrator for the purpose of conducting the requested review and confirming, modifying, or overruling the initial decision regarding the claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

ARTICLE VII

GENERAL PROVISIONS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Section 129 of the Code or any other provision of the Code applicable to the Plan.

7.2 Nonassignability. Any benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

7.3 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

7.4 Participant Litigation. In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

7.5 Addresses, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.6 Required Information. Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.7 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.8 Applicable Law. The Plan shall be construed under the laws of the State of California, to the extent not preempted by any Federal law.

Executed this _____ day of _____, _____.

Employer: TULARE COUNTY

_____

Attachment C

TULARE COUNTY
MEDICAL REIMBURSEMENT PLAN

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ARTICLE VII - GENERAL PROVISIONS

TULARE COUNTY
MEDICAL REIMBURSEMENT PLAN

ARTICLE I

INTRODUCTION

1.1 Creation and Title. The Employer hereby creates a welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as Tulare County Medical Reimbursement Plan.

1.2 Effective Date. The provisions of the Plan shall be effective as of January 1st, 2008.

1.3 Purpose. The purpose of the Plan is to provide reimbursement for certain medical expenses of Participants not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualify as an accident and health plan under Section 105(e) of the Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participants' income under Section 105(b) of the Code.

ARTICLE II

DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 "Agreement to Participate" means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Medical Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.

2.2 "Benefit Entry Date" means for each Eligible Employee the day that the Employee becomes eligible to participate in each of the Plan's Benefits. If the Plan does not have different eligibility requirements for each benefit, the Benefit Entry Date will be the same as the Plan Entry Date.

2.3 "Cafeteria Plan" means Tulare County Flexible Benefits Plan.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.5 "Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

2.6 "Dependent" means an individual who is a dependent within the meaning of Section 152(a) without regard to 152(b)(1, (b)(2), and (d)(1)(B) thereof of the Code of a Participant in the Plan.

2.7 "Effective Date" shall be January 1st, 2008.

2.8 "Eligible Employee" means an Employee, as defined in Section 2.9 below, who is eligible to participate in the Employer's health care program, and shall include employees who regularly work at least 40 hours per pay period, except for: (1) Employees who are Non-Resident Aliens (within the meaning of section 7701(b)(1)(B) of the Code deriving no earned income (within the meaning of section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3) of the Code), and (2) employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code(including sole proprietors and partners in a partnership),.

2.9 "Employee" means a person who is currently or hereafter employed by the Employer. Excluding individuals who are not contemporaneously classified as Employees of the Employer for purposes of the Employer's payroll system (including, without limitation, individuals employed by temporary help firms, technical help firms, staffing firms, employee leasing firms, professional employer organizations or other staffing firms whether or not deemed to be "common law" Employees or "Leased Employees" within the meaning of section 414(n) (o) of the Code) are not considered to be Eligible Employees of the Employer and shall not be eligible to participate in the Plan. In the event any such individuals are reclassified as Employees for any purpose, including without limitation, common law or statutory employees, by any action of any third party, including, without limitation, any government agency, or as a result of any private lawsuit, action, or administrative proceeding, such individuals shall notwithstanding such reclassification, remain ineligible for participation hereunder. Notwithstanding foregoing, the exclusive means for individuals who are not contemporaneously classified as an Employee of the Employer on the Employer's payroll system to become eligible to participate in this Plan is through an amendment to this Plan, duly executed by the Employer, which specifically renders such individuals eligible for participation hereunder.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision shall be final, binding and conclusive on all

parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

2.10 "Employer" means Tulare County.

2.11 "Form" means both physical as well as electronic "forms" or "documents" unless specifically Identified as a hard copy form or document.

2.12 "Medical Reimbursement Benefits" means, for any Plan Year, the amount available to a Participant as benefits in the form of reimbursements of Qualified Expenses.

2.13 "Medical Reimbursement Benefits Account" means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid.

2.14 "Participant" means any Employee who has met the eligibility requirements of Section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Agreement to Participate and Salary Reduction Agreement.

2.15 "Plan" means Tulare County Medical Reimbursement Plan, as described herein.

2.16 "Plan Administrator" means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan.

2.17 "Plan Entry Date" means for each Eligible Employee, the day that the Employee becomes eligible to participate in the Plan.

2.18 "Plan Year" means the 12-consecutive month period beginning on January 1st and ending on December 31st.

2.19 "Qualified Expenses" mean the medical expenses as defined in Section 213(d) of the Code incurred during a Plan Year by a Participant, the Participant's Spouse or the Participant's Dependents while the Participant is a Participant. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

2.20 "Salary Reduction Agreement" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Medical Reimbursement Benefits under the Plan.

2.21 "Spouse" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

2.22 "Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status.

ARTICLE III

PARTICIPATION

3.1 Eligibility. Each Employee, as defined in section 2.8 above, shall be eligible to participate in the Plan as follows:

- Tulare County Employees (except for members of the Tulare County Corrections Association and the Tulare County Deputy Sheriffs' Association) 1st day of the month following 30 calendar days of employment.
- Tulare County Corrections Association: 1st day of month following 60 calendar days of employment with the Probation Department.

Tulare County Deputy Sheriffs' Association: 1st full day of regular service with the Sheriff's Department.

3.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrollment Form setting forth the amount of Medical Reimbursement Benefits to be made available to the Eligible Employee for the immediately following Plan Year or remaining portion of the Plan Year. The Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Form. Each such new agreement shall specify the amount to be made available to the Participant for the immediately following Plan Year or remaining portion of the Plan Year covered by the agreement.

3.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) the date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 3.4;

(b) the date the Participant fails to make required contributions under the Plan;

(c) the end of the plan year the Participant ceases to be an Eligible Employee; or

(d) the date the Plan terminates.

3.4 Treatment of Rehired Employees. A Participant whose employment terminates and who is subsequently re-employed with less than 30 days separation of service will immediately rejoin the Plan with the same Benefit elections. Should the Participant return to service during the following Plan Year, the Participant would not be allowed to elect new Benefits prior to returning to service, unless the Employee should incur an applicable Change in Status.

A Participant whose employment terminates and who is subsequently re-employed with more than 29 days separation of service may immediately rejoin the Plan and may make new benefit elections. Any unused reimbursement Benefits Accounts balance prior to the initial separation of service date will be forfeited.

3.5 HIPAA Portability. Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Portability and Accountability Act of 1996 ("HIPAA") for coverage by an Accident or Health benefit under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

3.6 COBRA Continuation Coverage. Under COBRA, this section 3.6 shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a

typical business day during the preceding calendar year. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.7 Family Medical Leave Act. Under the FMLA, the provisions of this section 3.7 shall not be available to Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

Payment Options for coverage while on unpaid Family Medical Leave Act leave for group plans:

(a) Pre-pay before commencement of leave. **(b)** Pay-as-you-go. Employees may pay their share of premium payments on a monthly basis in advance (subject to any grace period as approved by the employer) or under another schedule permitted under Department of Labor regulations.

The Employer shall not be required to continue the health coverage of an Employee who fails to make required premium payments while on FMLA leave. However, if the Employer chooses to continue the health coverage of an Employee who fails to make required premium payment while on FMLA leave, the Employer is entitled to recoup those payments after the Employee returns from FMLA leave.

An "Eligible Employee" is an Employee of a covered Employer who:

(1) Has been employed by the Employer for at least 12 months, and
(2) Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave, and
(3) Is employed at a worksite where 50 or more Employees are employed by the Employer within 75 miles of that worksite. (See Section 825.105(a) regarding Employees who work outside the U.S.)

The 12 months an Employee must have been employed by the Employer need not be consecutive months. If an Employee is maintained on the payroll for any part of a week, including any periods of paid or unpaid leave (sick, vacation) during which other benefits or compensation are provided by the Employer (e.g., workers' compensation, group health plan benefits, etc.), the week counts as a week of employment. For purposes of determining whether intermittent/occasional/casual employment qualifies as "at least 12 months," 52 weeks is deemed to be equal to 12 months.Whether an Employee has worked the minimum 1,250 hours of service is determined according to the principles established under the Fair Labor Standards Act (FLSA) for determining compensable hours of work (see [29 CFR 785]). The determining factor is the number of hours an Employee has worked for the Employer within the meaning of the FLSA. The determination is not limited by methods of recordkeeping, or by compensation agreements that do not accurately reflect all of the hours an Employee has worked for or been in service to the Employer. Any accurate accounting of actual hours worked under FLSA's principles may be used. In the event the Employer does not maintain an accurate record of hours worked by an Employee, including for Employees who are exempt from FLSA's requirement that a record be kept of their hours worked (e.g., bona fide executive, administrative, and professional employees as defined in FLSA Regulations, [29 CFR 541]), the Employer has the burden of showing that the Employee has not worked the requisite hours. In the event the Employer is unable to meet this burden the Employee is

deemed to have met this test. See also 29 CFR Section 825.500(F). For this purpose, full-time teachers (see 29 CFR Section 825.800 for definition) of an elementary or secondary school system, or institution of higher education, or other educational establishment or institution are deemed to meet the 1,250 hour test. An Employer must be able to clearly demonstrate that such an Employee did not work 1,250 hours during the previous 12 months in order to claim that the Employee is not "Eligible" for FMLA leave.

The determinations of whether an Employee has worked for the Employer for at least 1,250 hours in the past 12 months and has been employed by the Employer for a total of at least 12 months must be made as of the date leave commences. If an Employee notifies the Employer of need for FMLA leave before the Employee meets these eligibility criteria, the Employer must either confirm the Employee's eligibility based upon a projection that the Employee will be eligible on the date leave would commence or must advise the Employee when the eligibility requirement is met. If the Employer confirms eligibility at the time the notice for leave is received, the Employer may not subsequently challenge the Employee's eligibility. In the latter case, if the Employer does not advise the Employee whether the Employee is eligible as soon as practicable (i.e., two business days absent extenuating circumstances) after the date Employee eligibility is determined, the Employee will have satisfied the notice requirements and the notice of leave is considered current and outstanding until the Employer does advise. If the Employer fails to advise the Employee whether the Employee is eligible prior to the date the requested leave is to commence, the Employee will be deemed eligible. The Employer may not, then, deny the leave. Where the Employee does not give notice of the need for leave more than two business days prior to commencing leave, the Employee will be deemed to be eligible if the Employer fails to advise the Employee that the Employee is not eligible within two business days of receiving the Employee's notice.

The period prior to the FMLA's effective date must be considered in determining Employee's eligibility.

Whether 50 Employees are employed within 75 miles to ascertain an employee's eligibility for FMLA benefits is determined when the Employee gives notice of the need for leave. Whether the leave is to be taken at one time or on an intermittent or reduced leave schedule basis, once an Employee is determined eligible in response to that notice of the need for leave, the Employee's eligibility is not affected by any subsequent change in the number of Employees employed at or within 75 miles of the Employee's worksite, for that specific notice of the need for leave. Similarly, an Employer may not terminate employee leave that has already started if the Employee-count drops below 50. For example, if an Employer employs 60 Employees in August, but expects that the number of Employees will drop to 40 in December, the Employer must grant FMLA benefits to an otherwise Eligible Employee who gives notice of the need for leave in August for a period of leave to begin in December.

ARTICLE IV

BENEFITS

4.1 Provision of Benefits. Benefits under the Plan shall take the form of reimbursement of Qualified Expenses incurred by a Participant, the Participant's Spouse and the Participant's Dependents during the Plan Year.

4.2 Amount of Reimbursement. A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Medical Reimbursement Benefits. The amount of a Participant's Medical Reimbursement Benefits shall be uniformly available during the Plan Year.

4.3 Change in Participant Election. A Participant may not change the amount of Medical Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to a change in status in the Cafeteria Plan.

4.4 Nondiscriminatory Benefits. The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.5 Maximum Benefits. Notwithstanding any other provisions of this Plan, no Participant shall receive Medical Reimbursement Benefits in excess of $2500 per Plan Year.

ARTICLE V

FUNDING AND PAYMENT OF BENEFITS

5.1 Funding. Contributions to the Plan for the Plan Year shall be limited to the amounts determined by the Salary Reduction Agreements entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

5.2 Participants' Accounts. The Plan Administrator shall establish a separate Medical Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Medical Reimbursement Benefits Account with the amount of Medical Reimbursement Benefits to be made available to the Participant pursuant to the Agreement to Participate. The Plan Administrator shall charge a Participant's Medical Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The Plan Administrator may also establish a minimum reimbursement amount below which requests for reimbursement shall not be made during the Plan Year, but which must be made by the end of the Plan Year (including the period set forth in Section 5.4).

5.3 Payment of Benefits. Reimbursement shall only be made under the Plan on the basis of Qualified Expenses incurred by the Participant, the Participant's Spouse or the Participant's Dependents, as presented to the Plan Administrator on a written form specified by the Plan Administrator and as evidenced by a written statement from a third party. It shall be the duty of the Plan Administrator to construe what are and what are not Qualified Expenses subject to reimbursement from a Participant's Medical Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Qualified Expense subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Qualified Expense within a reasonable time. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

(a) the name of the person or persons for whom the expenses have been incurred;

(b) the nature of the expenses incurred;

(c) the date the expenses were incurred;

(d) the amount of the requested reimbursement; or

(e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Qualified Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse,

(c) Family member held responsible for payment of deceased's medical bills,

(d) Spouse of dependent with COBRA continuation rights.

5.4 Forfeiture of Benefits. A Participant forfeits any amount of Medical Reimbursement Benefits under the Plan for a Plan Year if a claim for reimbursement is not provided to the Plan Administrator within 90 days after the last day of the Plan Year. Upon such forfeiture, the Participant's Medical Reimbursement Benefits Account shall be reduced to zero. At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

ARTICLE VI

PLAN ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

6.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 105 of the Code.

6.3 Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions of Section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake

of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 60 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures.

If requested in writing, and within 60 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim. The Employer's representative, the Human Resources Director or designee, shall serve as the Plan Administrator for the purpose of conducting the requested review and confirming, modifying, or overruling the initial decision regarding the claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

ARTICLE VII

GENERAL PROVISIONS

7.1 **Amendment and Termination.** The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Section 105 of the Code or any other provision of the Code applicable to the Plan.

7.2 **Nonassignability.** Any benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

7.3 **Not an Employment Contract.** By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

7.4 **Participant Litigation.** In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

7.5 **Addresses, Notice and Waiver of Notice.** Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.6 **Required Information.** Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.7 **Severability.** In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.8 **Applicable Law.** The Plan shall be construed under the laws of the State of California, to the extent not preempted by any Federal law.

Executed this _____ day of _____, _____.

Employer: TULARE COUNTY

_____

Attachment D

Tulare County Flexible Benefits Plan

NOTICE OF PRIVACY PRACTICES

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Originally Effective January 1st, 2008, Revised January 1st, 2008.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR PERSONAL AND HEALTH INFORMATION IS IMPORTANT.

Tulare County is committed to protecting the privacy of health information maintained by the health plans it sponsors. This Notice is provided to you as required by the Health Insurance Portability and Accountability Act and the HIPAA Privacy Regulations (collectively, "HIPAA"). It applies to employees and covered dependents enrolled in Tulare County Flexible Benefits Plan, hereinafter "the Plan".

This Notice describes how the Plan may use health information about you and your covered dependents and when such information may be used and disclosed. This notice also describes how you may have access to this information.

WHAT HEALTH INFORMATION IS COLLECTED?

The Plan considers personal health information to be confidential. The Plan will protect the privacy of that information in accordance with federal and state privacy laws, as well as the Plans' privacy policies. "Health Information" is used to mean information that identifies you and relates to your medical history, such as the health care you receive and or the amounts paid for that care.

Health information subject to the provisions explained in this Notice is information maintained by the Plan. The provisions do not extend to similar information which may be on file with Tulare County as an Employer in its normal course of doing business. The type of health information typically received and maintained by the Plan which is subject to this Notice includes enrollment and claims information, benefit determinations, appeals information, eligibility, and case management information.

SUMMARY OF PERMISSIBLE USES AND DISCLOSURES AND YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION WHICH DO NOT REQUIRE YOUR AUTHORIZATION

In order to provide and administer your benefits, the Plans may use and disclose your health information in various ways without your express authorization. These include:

- **Payment:** The Plan may use and disclose your health information for purposes of paying for your health care services or to obtain premiums/contributions from you. The Plan may also use and disclose your health information to make determinations about your eligibility for benefit plan coverage, for coordination of benefits with other benefit plans, to perform claims management and collection activities, to review the medical necessity or the appropriateness of the care you received, and to conduct utilization reviews such as pre-authorizations, or reviews, of services.
- **Health Care Operations:** The Plan may use and disclose your health information as necessary to operate and manage their business operations. For example, Tulare County, on behalf of the Plan, has contracts with an outside firm called a "third party administrator" (TPA) to provide administrative services to the Plan. The Plan may use your health information to evaluate the performance of the TPA in managing and providing you with health care benefits. The Plan might use and disclose your

health information to contract for reinsurance or to investigate the validity of benefits claims. In addition, the Plan may share your health information with another company that performs certain services, such as billing or compiling information to help the Plan determine how the Plan is doing relative to other plans. Whenever the Plan has such an arrangement, they will have a written confidentiality agreement to ensure that the company that performs these services will protect the privacy of your health information, maintain its confidentiality and limit the uses or further disclosures to the purpose for which the information was disclosed or as required by law.

- **Benefits and Services:** As a part of health care operations, the Plan may use your health information to contact you regarding benefits or services that may be of interest to you, such as benefits that are included in the Plan, your medical treatment, case management and coordination of benefits, recommendations for alternative treatments, therapies, health care providers or settings of care.
- **Employer:** The Plan may disclose certain health information to Tulare County since it is the Employer which sponsors the Plan. Upon a request from Tulare County, the Plan may disclose health information about enrolled employees and their covered dependents to enable the Employer to obtain premium bids from other health plans, or to modify, amend, or terminate the Plan; however, the information the Plan discloses in such situations will not include any information that explicitly identifies individuals. The Plan may disclose to the Employer information on whether you are participating in, enrolled in, or unenrolled from the Plan. The Plan also may disclose health information about you, including information that identifies you, only if it is necessary for the Employer to administer the Plan. For example, Tulare County may need such information to process health benefits claims, to audit or monitor the business operations of the Plans, or to ensure that the Plans are operating effectively and efficiently. The Plan may also disclose information to the Employer with respect to workers' compensation and the Family and Medical Leave Act. The Plan, however, will restrict their use of your information to purposes related only to Plan administration. The Plan prohibits the Employer from using your information for uses unrelated to Plan administration. Under no circumstances will the Plan disclose your health information to the Employer for the purpose of employment-related actions or decisions. The Employer will only disclose the health information it received from the Plan to third parties, such as to consultants or advisors, if the Plan has first obtained a confidentiality agreement from the person or organization which will receive your health information.
- **Disclosures to Friends and Family Involved in Your Care and Payment for Your Care:** The Plans may share information about your health benefits to a person involved in your care such as a family member unless you object. If you have provided a friend or family member with copies of your claim and other relevant identifying information, the Plan will assume that you do not object.
- **Emergencies or Public Need:** The Plan may use or disclose your health information in an emergency or for important public needs. For example, the Plan may share your information with public health officials authorized to investigate and control the spread of diseases. The Plan may have information to prevent or lessen a serious and imminent threat to health or safety.
- **As Required By Law:** The Plan may use or disclose your health information if the Plan is required by law to do so. The Plan will notify you of these uses and disclosures if notice is required by law.
- **Business Associates:** The Plan may share information with service providers who provide administrative services for the Plans.

USES AND DISCLOSURES OF HEALTH INFORMATION WHICH REQUIRE YOUR WRITTEN AUTHORIZATION

Except as otherwise described in this Notice, the Plan, through their third party administrator, will generally obtain your written authorization before using your health information or disclosing it outside the Plan. If you provide the Plan with such a written authorization, you may revoke that authorization at any time, except to the extent that the Plans have already relied on it. To revoke an authorization, write to the Plan Administrator or Privacy Officer.

Access and Control of Your Health Information

The Plan must provide you certain rights with respect to access and control of your health information in your health claims file. You have the following rights to access and control your health information:

- You generally have the right to inspect and copy your health information which the Plan maintains.
- You have the right to request that the Plan amend your protected health information if you believe it is inaccurate or incomplete. You must submit your request in writing to the third party administrator of the Plan in which you are enrolled.
- You have the right to receive from the Plan an accounting of disclosures of protected health information. Your request must be in writing to the Privacy Officer. Many routine disclosures the Plan makes, including disclosures to your Employer for Plan administration, will not be included in the accounting; the accounting will identify only non-routine disclosures.
- You have the right to request further restrictions on the way the Plan uses your health information or shares it with others. The Plan is not required to agree to the restriction you request, but if the Plan does, the Plan will be bound by the agreement until such agreement is revoked by the Plan and you are notified in writing of such revocation.
- You have the right to request that the Plan contact you in a way that is more confidential for you, such as at work instead of at home, if disclosure of your health information could put you in danger and you clearly state that in your request. The Plans will accommodate all reasonable requests.

To Have Someone Act on Your Behalf
You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. This authorization must be in writing and delivered to the Privacy Officer for the Plan.

Special Protections for HIV, Substance Abuse, and Mental Health Information
Special privacy protections may apply to HIV-related information, substance abuse information, and mental health information. Some parts of this Notice may not apply to these types of information.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, please contact the Privacy Officer listed at the end of this notice:

No one will retaliate or take action against you for filing a complaint.

Right to Revise
The Plan may change its privacy practices from time to time. If that happens, the Plan will revise this Notice so you will have an accurate summary of the Plans' practices. The revised Notice will apply to all of your health information. If you received this Notice electronically, you have the right to obtain a paper copy of the Notice. To request a paper copy of this Notice or any revised Notice, please contact the Plan's Privacy Officer. If this Notice is substantially revised, a new Notice will be mailed to you within 60 days.

The Plan is required by law to abide by the terms of the Notice currently in effect.

Contact Information
For further information, please contact the Plans' Privacy Officer:

Monica Emerson, Employee Benefits Manager
Tulare County
2900 W. Burrel
Visalia, CA 93291
559-733-6266

Tulare County Flexible Benefits Plan
HIPAA Privacy Plan Amendment

Article 1. Introduction

Tulare County ("the Plan Sponsor") sponsors Tulare County Flexible Benefits Plan ("the Plan"). Certain employees of the Company have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations implementing it, limit the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI shall apply to this plan amendment:

> *Protected Health Information.* Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this plan amendment or as otherwise required or permitted by HIPAA.

Provision of Protected Health Information to Plan Sponsor

Article 2. Permitted Disclosure of Enrollment Information

The Plan, or any insurance carrier under the plan, may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has unenrolled from any benefit offered by the Plan.

Article 3. Permitted Uses and Disclosure of Summary Health Information

The Plan, or any insurance carrier under the plan, may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Article 4. Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes:

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Article 5 and obtaining written certification pursuant to Article 7, the Plan or any insurance carrier under the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the

Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, adjudication, appeal, payment, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, nor to any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR 164.504(f).

Article 5. Conditions of Disclosure for Plan Administration Purposes

Plan Sponsor agrees that with respect to any PHI, other than enrollment information and Summary Health Information which are not subject to these restrictions, disclosed to it by the Plan or health insurance carrier under the Plan, Plan Sponsor shall:

a. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
e. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR 164.524;
f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526;
g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528;
h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
i. 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, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
j. Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR 504(f)(2)(iii), is satisfied.

Article 6. Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall allow Benefits Department access to the PHI. No other persons shall have access to PHI. The specified employees, or classes of employees, shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event the above named individuals or groups are unavailable to carry out their duties with respect to the Plan, the Plan Sponsor may appoint other persons as necessary to carry out plan administration functions. The Plan Sponsor shall promptly notify the Privacy Officer of such occurrence.

In the event that any named individual does not comply with the provisions of this article, that employee shall be subject to disciplinary action by the Plan Sponsor pursuant to the Plan Sponsor's employee disciplinary and termination procedures.

Article 7. Plan Sponsor Certification

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Article 5 of this amendment.

This Plan Amendment is effective the 1st day of January, 2008, and has been adopted by:

_____
Plan Sponsor Representative Signature

_____
Plan Sponsor Representative Name

_____
Plan Sponsor Representative Title

_____
Date

Attachment E

TULARE COUNTY
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Summary Plan Description

Table of Contents

Article I

INTRODUCTION TO YOUR PLAN

Tulare County offers a "Flexible Benefits Plan" as part of your employee benefits program. This Plan was revised on January 1st, 2008. This Plan is intended to qualify under Section 125 of the Internal Revenue Code (IRC). Under IRC Section 125, you can take advantage of the tax-free benefits offered under the Plan, as described in this summary.

Your Plan is a "Salary (or wage) Reduction" plan. This means that you pay your share of the cost of your benefits by electing to have your compensation reduced. But, both you and the Employer contribute to pay for these benefits. Your Employer can temporarily reduce or increase your portion of the cost. The Employer pays its portion out of its general assets. To pay your share, you must file a Benefits Enrollment Form which contains a "Salary (or wage) Reduction Agreement" with the Plan Administrator. This form lists both the benefits selected plus the amount you have agreed to contribute to pay for those benefits. Then, the Employer will deduct from your paycheck, an amount sufficient to pay for your portion of your benefits.

Any money you contribute to pay for your benefits is not subject to Federal income, Social Security or Unemployment taxation. Therefore, your benefit costs are lower and, in some cases, can even result in a net increase in spendable income to you, after paying for your benefits. This can be illustrated by the following example:

	With Your Plan	**Without Your Plan**
	---	---
Gross Taxable Wages	$25,000.	$25,000.
Pre-tax Contribution	$1,800.	N/A
	---	---
Taxable Wages	$23,200.	$25,000.
Estimated Taxes*	$3,480.	$3,750.
After-tax Contribution	N/A	$1,800.
	---	---
Take-home Pay	$19,720.	$19,450.

* Joint Return, 15% marginal tax rate

By paying for benefits before taxes are calculated, estimated taxes are reduced by $270, which is $22.50 per month more in take-home pay for our example person. In other words, paying for benefits without a Flexible Benefits Plan costs this person $22.50 more per month. Please consult your tax advisor for a more accurate estimate for your situation.

This Summary Plan Description is a brief description of the Plan and your rights, benefits and obligations under the Plan. This Summary Plan Description is not meant to interpret, extend or change any provision contained in the main Plan Document. The provisions of Tulare County Flexible Benefits Plan can only be accurately understood by reading the Plan Document. This Document is on file with the Employer and may be read by you or your dependents or your legal representative by contacting the Benefits Staff. The Benefits Staff's office will make the Document available to you at any reasonable time. You may request a copy of the Plan from the Plan Administrator, who may charge you a fee for copying the Plan for you.

Article II

GENERAL INFORMATION

You may need the following information if you have any questions about your Plan.

1. GENERAL PLAN INFORMATION

The name of this Plan is Tulare County Flexible Benefits Plan.

Your Employer has assigned Plan Number 520 to this Plan.

The provisions of your Plan became effective on January 1st, 2008.

This Plan's records are maintained on a 12-month period known as the Plan Year. The Plan Year for your Plan is January 1st through December 31st.

Your Plan shall be governed by the Laws of the State of California.

2. EMPLOYER INFORMATION

The name, address and tax identification number of the Employer are:

Tulare County
2900 W. Burrel
Visalia, CA 93291
559-733-6266
94-6000545

3. PLAN ADMINISTRATOR INFORMATION

The name, address and telephone number of your Plan Administrator are:

Tulare County Human Resources & Development
2900 W. Burrel
Visalia, CA 93291
559-733-6266

Your Plan Administrator is responsible for the administration of your Plan. Should you need to see any records or have any questions regarding the Plan, contact the Plan Administrator.

4. BENEFITS COORDINATOR AND STAFF

Monica Emerson, Employee Benefits Manager has been named as the Plan's Benefits Coordinator. If you need additional

information about the plan or the benefits offered, the Benefits Coordinator will be able to assist you.

5. LEGAL REPRESENTATIVE

The following person has been named your Plan's agent for service of legal process:

Tulare County Counsel
2900 W. Burrel
Visalia, CA 93291

Service of process can also be made upon the Plan Administrator.

Article III

PARTICIPATION IN YOUR PLAN

All employees who meet the participation requirements are eligible to participate in this Plan.

To qualify as a participant under this Plan, you must meet the following requirements:

- Tulare County Employees (except for members of the Tulare County Corrections Association and the Tulare County Deputy Sheriffs' Association) 1st day of the month following 30 calendar days of employment.
- Tulare County Corrections Association: 1st day of month following 60 calendar days of employment with the Probation Department.
- Tulare County Deputy Sheriffs' Association: 1st full day of regular service with the Sheriff's Department.

Employees who fall into the following groups are excluded from participating in the Plan:

- Part-Time Employees who work less than 20 hours per pay period.

- Employees who are non-resident aliens and receive no earned income from the employer which constitutes income from sources within the United States.

If you become eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for coverage by an Accident or Health Benefit available under the Plan you shall be allowed to participate in the Plan, so long as you comply with the provisions set out in HIPAA. See your Plan Administrator for details.

Your Plan Entry Date, the date you may actually join the Plan, is on the date you meet all of the above eligibility requirements subject to special conditions for various plans other than the medical plans.

BENEFITS ENROLLMENT FORM

You will be required to file a Benefits Enrollment Form before either one of two dates. If your plan has different eligibility requirements, you will have different benefit entry dates for each benefit. If your plan has one set of eligibility requirements, the benefit entry dates will be the same as the plan entry dates. The benefits enrollment form needs to be filed before any applicable benefit or plan entry dates. The Benefits Enrollment Form is an agreement between you and your Employer, where your Employer lists the benefits offered for the Plan Year. It will also specify the amount you have agreed to contribute towards the cost of these benefits, in the Salary (or Wage) Reduction Agreement part of the form. This is an agreement between you and your Employer, which states that you agree to have your compensation reduced by the amount necessary to pay for the benefits. Any money you contribute to this Plan will not be subject to Federal income taxation.

If you do not file a new Benefits Enrollment Form with the Plan Administrator before the start of the new Plan Year, it will be assumed that you selected the same benefits as in the previous Plan Year, and your compensation will be reduced accordingly by the Employer. . In addition the employer reserves the right to change the pre-tax status of your contributions and to cease paying the benefit amount otherwise provided by employer in accord with County policies. If you do not want to participate in your Plan for the new Plan Year, you must inform the Plan Administrator in writing of your wish.

LIMITATIONS ON CONTRIBUTIONS

The Maximum Contribution you can make to this Plan is an amount equal to the total cost of purchasing the most expensive

premium-type benefit available from each Benefit Category plus the amount you defer to reimbursement-type programs under this Plan. "Benefit Category" refers to each category of benefits such as health insurance, group term life insurance, or disability insurance. These are examples only, the actual benefits offered under this Plan are detailed in Section VI.

CHANGE IN ELECTIONS/CHANGE IN STATUS

The laws governing Flexible Benefits Plans generally do not allow you to change the terms of your Benefits Enrollment Form during a Plan Year. There are, however, a few exceptions to this rule. You may change your benefit elections if there is a change in your status. If you are enrolled in the Tulare County Medical Reimbursement Plan, these changes are limited to: the marriage or divorce of the Participant; the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment of the Participant or Participant's Spouse; change in the Participant's residence; the Participant beginning or ending adoption proceedings, or; Medicare or Medicaid entitlement. If you are enrolled in the other benefits provided by the Plan, your changes would be limited to: the marriage or divorce of the Participant; the adoption, birth, or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; the employment of the Participant or Participant's Spouse; change in the Participant's residence (to the extent eligibility for participation in a particular plan is subject to geographic limitations); the Participant beginning or ending adoption proceedings; automatic changes upon cost increases or decreases; ; significant curtailment of coverage; addition or elimination of similar benefit package option allowing (prohibiting) employees that previously opted out of other benefits to make an election change; change in coverage under employer plan of spouse or dependent; FMLA leaves; ; HIPAA special enrollment rights; a COBRA qualifying event; a judgment, decree or order, or; Medicare or Medicaid entitlement.

You do need to submit any changes to your election within 30 days of any applicable event.

Also, you (or your estate) will not be required to make further contributions to the Plan once you have died, retired, terminated employment, or have a change in job status so that you are no longer eligible to participate under this Plan.

Note that the new benefit elections can start only after your change in status has taken place and the new form has been filed. For example, assume that you have a change in status from the list above. You could request a change in your benefits ahead of time to be effective on the date of the event. However, making other unrelated changes or changes that are effective before the date of the event would not be approved.

Also, you may be required to increase your contribution if the Plan's cost for a particular benefit should increase during the Plan Year. If, for example, premiums for health insurance offered under the Plan are raised during the year, you will have the option of either paying your share of the increased premiums or selecting another health insurance option offered under the Plan.

ENDING PLAN PARTICIPATION AND LEAVES OF ABSENCE

Because you contribute to this plan on a pre-tax basis, you must be receiving pay from your employer in order to make those contributions. Usually, your participation in the plan will end when you stop making pre-tax contributions. The rest of this section explain the rules regarding suspending or ending your participation in the plan.

Ending Plan Participation

A Participant whose employment terminates and who is subsequently re-employed with less than 30 days separation of service will immediately rejoin the Plan with the same Benefit elections. Should the Participant return to service during the following Plan Year, the Participant would not be allowed to elect new Benefits prior to returning to service, unless the Employee should incur an applicable Change in Status.

A Participant whose employment terminates and who is subsequently re-employed with more than 29 days separation of service may immediately rejoin the Plan and may make new benefit elections. Any unused reimbursement Benefits Accounts balance prior to the initial separation of service date will be forfeited.

Continuing Plan Participation Under COBRA and FMLA

Special rules, called COBRA provisions, apply to certain health or medical plans. If you terminate employment or have another "qualifying event" that affects your health plan, your Benefits Staff will give you an explanation of COBRA and your rights to continued coverage, if COBRA applies to your plan.

The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting the employee or a family member.

If you are on an unpaid leave under the FMLA rules, you may continue to participate in the plan, by making contributions under one of the options elected by your employer.

The payment options for coverage while on unpaid Family Medical Leave Act leave for group health plans are:

i) Pre-pay. Under this option, you will pay your share of premium payments that will be due during your leave, before your FMLA leave begins.

ii) Pay-as-you-go. Under this option, you will pay your share of premium payments on a monthly basis in advance (subject to any grace period as approved by the employer) , or under another schedule according to Department of Labor regulations. If you fail to make payments under this Pay-as-you-go option, your Employer is not required to continue coverage. However, if your Employer chooses to continue coverage, your employer is entitled to collect these amounts from you after you return from the FMLA leave.

Ending your participation in a reimbursement benefit affects the way the Plan Administrator will handle your requests for reimbursement, too. These rules for reimbursement benefits are explained in Article VI.

Article IV

PAYING FOR BENEFITS UNDER YOUR PLAN

INTRODUCTION

There are two basic types of benefits offered under your plan: Premium benefits and Reimbursement benefits.

Premium benefits are insurance benefits, such as health, life and disability insurance.

Reimbursement benefits are benefits where you designate a portion of your salary (or wage) reduction contributions to be placed in an account for you. You can later have the Plan reimburse you when you have expenses to pay that are considered "Qualified Expenses" under the Plan. Your Plan offers reimbursement for certain medical and dependent care expenses, as authorized under the Internal Revenue Code.

PAYMENT OF PLAN EXPENSES

The cost of the plan includes administrative expenses and the amount paid to provide benefits such as premium payments to insurance companies and reimbursement benefits. The amount needed to provide your benefits depends on the selections you made on the Benefits Enrollment Form. You and your Employer share in the cost of your benefits under your Plan. For the purposes of this plan the County's Benefit Amount constitutes the Employer Contribution. The Employer pays its portion from all applicable revenues and you pay your portion through salary (or wage) reductions.

Article V

ADMINISTRATION OF YOUR PLAN

The Plan Administrator is responsible for the administration of your Flexible Benefits Plan. The duties of the Plan Administrator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan.

When you are ready to enter the Plan, you must file a Benefits Enrollment Form and Salary (or Wage) Reduction Agreement with the Plan Administrator. After becoming a participant in the Plan, file all change requests and requests for reimbursement with the Plan Administrator. The Plan Administrator will determine, in accordance with the various laws that apply to Flexible Benefits Plans, whether or not to grant your requests.

The Plan Administrator can demand any documents or evidence deemed necessary to properly administer your Plan. If the Plan Administrator feels that you have submitted insufficient data to make a determination, or that the request made is not allowed under the Plan, the Plan Administrator can deny your request. After the request has been denied, you will be allowed an opportunity to appeal. The Plan Administrator must furnish you in writing the reasons for the denial of your claim for benefits. The written denial must be provided to you within 60 days of the date the claim for benefits was received by the Plan Administrator. The written denial must refer to the Plan provision, or section of the Internal Revenue Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures.

If requested in writing, and within 60 days of the claim denial, the Plan Administrator is required to give you a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify you in writing of his final decision on the reviewed claim. The Employer's representative, the Human Resources Director or designee, shall serve as the Plan Administrator for the purpose of conducting the requested review and confirming, modifying, or overruling the initial decision regarding the claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

If your request was denied because the Plan Administrator felt your request is not covered under the Plan, you will be given the chance to show why it should have been allowed under the Plan. If the Plan Administrator rejects your reasons, you will not be able to appeal again.

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In addition to interpreting the plan and making sure that benefits are properly paid, the Plan Administrator also keeps all the records of the Plan. Should you need a copy of anything filed with the Plan Administrator, contact the Plan Administrator directly.
Plan Administrator includes Tulare County and any third party administrator selected by the County. Duties performed by any third party administrator shall be determined by the context within which the term is used in this document. The County retains the ultimate responsibility for the administration of the plan, notwithstanding the above.

Article VI

BENEFITS UNDER YOUR PLAN

INTRODUCTION

Your Flexible Benefits Plan offers several benefit options. It is very important that you make benefit choices that fit your benefit needs. You should not, for example, choose a benefit just because it is the least expensive if that benefit will not fit your needs. When making your decision as to what benefits are best for you, you should consider factors such as whether you have benefits from another source (such as coverage under a similar plan by your spouse's employer), the number of dependents you are covering and the amount you can afford to spend. Your Benefits Staff will be glad to assist you in making the best benefit choices for your particular situation.

HEALTH INSURANCE BENEFITS

There are multiple insurance health benefits offered under your Flexible Benefits Plan. You can choose benefits for your dependents, as well, at an additional charge.

The health insurance program has a deductible, co-payments and co-insurance payments. A "deductible" is the amount you must pay out of your own pocket before the health insurance company will begin paying its portion of the benefits.

Remember, you can have your deductible, co-payments and co-insurance payments paid out of the Medical Reimbursement Program. For specific coverages and deductible, co-payments and co-insurance payments, consult the Summary Plan Description of the health insurance policy, available from the Benefits Staff.

The HMO or PPO offered under this plan may have different restrictions, coverages and charges from the basic health insurance. You may be encouraged (or required) to select your doctor from a list of participating physicians. Also, deductibles, co-payments and other fees will vary among health care alternatives. Consult each health alternative's enrollment materials or Summary Plan Description for a description of the benefits, limitations and costs. This information can be obtained from your Benefits Coordinator.

VISION AND DENTAL BENEFITS

Vision and dental benefits are part of your bundled health program. . Various coverages are available.

A copy of the Summary Plan Description for the vision and dental plans is available from the Benefits Staff. It describes the specific coverages and limitations available.

GROUP TERM LIFE INSURANCE

Your Flexible Benefits Plan offers group term life insurance as one of your benefit options. Several different group term life policies, with different coverages, are available.

Group term life insurance provides a cash benefit to your beneficiary, such as your spouse, should you die unexpectedly. Unlike whole life insurance, group term life does not build a cash fund (or cash values) during its term. Thus, group term life insurance does not help you accumulate additional money for retirement. However, the price of a group term life insurance policy is considerably less than that of other life insurance.

Ask to see the Summary Plan Description for the group term life insurance benefits available under this Plan. It is on file with the Benefits Staff and has information about specific coverages, limitations and restrictions under your Flexible Benefits Plan.

DISABILITY BENEFITS

Your Flexible Benefits Plan offers disability insurance as one of your benefit options.
Disability insurance helps to preserve a substantial part of your income in case you become severely ill or injured and are unable to work. Should you become severely injured or are unable to work, a determination will be made as to whether or not you qualify for disability coverage under the Plan. If it is determined that you are disabled, you will begin receiving disability benefits. You should be aware that there is a waiting period between the time you become sick or injured and the time you can begin receiving disability benefits.

Also, some disability insurance policies require that your disability benefits be reduced by a portion of any money you receive from Social Security for disability benefits.

Ask to see the Summary Plan Description for the disability benefits available under the Plan. It is on file with the Benefits Staff and has information about specific coverages, limitations, restrictions and waiting periods concerning the various disability benefits being offered under your Flexible Benefits Plan.

QUALIFIED SUPPLEMENTAL BENEFITS

Accident, Disability, Cancer and Medical Gap Plan

REIMBURSEMENT PROGRAMS

INTRODUCTION

Your Flexible Benefits Plan allows you to direct some of your salary (or wage) reductions so that this money can later be returned to you, tax free, to pay for certain allowed expenses, called qualified expenses.

In order for an expense to be eligible for reimbursement it must be "qualified", as explained below. It must also be incurred during the period of coverage (usually the plan year). This means that you must have received services, such as having seen the doctor or had a child in day care, on a date during the period covered by your Benefits Enrollment Form.

Assume that your enrollment is effective as of March 1. If you saw the doctor on February 28, that expense would not be eligible for reimbursement, even if you received an invoice dated after March 1.

The coverage period for the reimbursement program always ends on the last day of the plan year. However, if you stop making contributions to the plan because you have a change in status or otherwise end participation, you also change your election amount to equal the amount in your account as of the date contributions stopped. This means that you may incur expenses at any time up to the last day of the plan year. However, your reimbursement is limited to the amount in your account.

(eliminated caps) Once you have elected to defer money to one of the programs below, you cannot change that election, subject to the exception regarding a change in status. Any money left over at the end of the plan year in these programs becomes the property of the employer. The plan administrator will finish the accounting for the plan year 90 days after the last day of the plan year. You must submit any remaining claims for reimbursement before that date. Should you fail to spend all the money you defer to a reimbursement program before the end of a plan year, you cannot carry that money over to the next plan year. It is, therefore, very important that you determine as accurately as possible how much you wish to defer to a reimbursement program. The Benefits Staff will be glad to assist you in making an accurate assessment of your needs under these programs.

TULARE COUNTY MEDICAL REIMBURSEMENT PLAN

Money directed into the Medical Reimbursement Program will be returned to you, tax free, to pay for any qualified medical expenses that are not covered by medical insurance. The maximum amount you may defer to this program is $2500 per Plan Year.

Qualified expenses under the Medical Reimbursement Program might include medical expenses that are not covered under your medical insurance program. Thus, co-payments, deductibles, co-insurance payments for certain excluded coverages,

expenses for prescriptions or medical supplies that are not paid for by insurance could be considered expenses that can be reimbursed under your Medical Reimbursement Program.

Examples of expenses eligible for reimbursement under this Program would include: hospitalization and clinical care; prescription and over-the-counter drugs; transportation expenses (such as an ambulance) incurred to get medical services; home improvement costs that are recommended by a doctor and necessary for treatment or rehabilitation, to the extent such improvement does not increase the value of your home.

The following examples would usually not qualify as expenses eligible for reimbursement, even though recommended by a doctor: expenses for cosmetic surgery or cosmetic items, maternity items or wigs (unless ordered by a doctor as essential to health); vacation or travel expenses, even if for rehabilitation or prescribed by a doctor; meals and lodgings (unless included as part of a hospital bill or while traveling between distant hospitals) at a location away from home, even if prescribed by a doctor or received as an outpatient.

The Plan is required to pay you any benefits you incur, up to the maximum you elected, at any time. For example, assume that you have elected to establish a Medical Reimbursement account of $600 for the Plan Year, $50 each month. During the first month when there is only $50 in your account, you have qualified medical expenses of $300. The Plan must reimburse you the full $300 and take the risk that you might terminate employment before the full $300 has been contributed.

TULARE COUNTY DEPDENDENT DAYCARE PLAN

Qualified expenses under the Dependent Care Assistance Program include any expenses that you could take as a credit against tax on your income tax form for the care of a dependent. A dependent eligible for these expenses includes a child or any other relative for whom you take a tax deduction on your tax form. A person is a dependent of yours if you provide them with at least 50% of their living expenses over the course of the year.

Dependents eligible under this program include children under the age of 13, and physically or mentally incapacitated individuals who are in need of supervised care.

Before deciding to participate in the Dependent Care Assistance Program, you should know that there is a provision in the Federal Income Tax Code that allows you to take a credit against taxes for Dependent Care Assistance Expenses. Section 21 of the Internal Revenue Code allows taxpayers to take a credit against tax of up to $3,000 per qualified dependent, up to a maximum of $6,000, per year for dependent care assistance expenses. These amounts are for 2003 and may vary from year to year. This allowable tax credit may be more advantageous for lower-paid Participants in this Plan. Consult your tax advisor to determine if participating in this Program or taking the tax credit under Internal Revenue Code Section 21 would be better for you.

Also, the tax laws further limit how much you can contribute to this Program. Under the law and the terms of the Plan, you can defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or $5000 per year to this Program.

Generally, you can't receive reimbursements under this Program if you are married and your spouse doesn't work. However, if your spouse is a full-time student or unable to work, then your spouse is deemed to have a monthly income of $250, if you have one dependent, $500 if you have two or more dependents.

You can apply for reimbursement for household service expenses, including payments to baby-sitters, maids, nurses and cooks who work in your house, at least to the extent their services are for the care of a qualified individual. Household service expenses would not include payments to a gardener or chauffeur.

Out-of-home expenses would include payments for well-being and protection of qualified individuals. This would include nursery school, day-care centers, and certain summer camp expenses. This does not include expenses for educational expenses for children in kindergarten or beyond, or food, clothing and transportation expenses.

In order to qualify as a day care center, the center must care for at least six individuals who do not live on the premises, and comply with all applicable state and local laws.

Out-of-home care expenses for your spouse or dependents over the age of 12 who are unable to care for themselves qualify under this Program only if those individuals regularly spend at least eight hours each day in your home. Therefore, nursing home expenses do not qualify under this Program. However, in-house expenses for these individuals would.

You cannot receive reimbursement for dependent care services provided BY your child under the age of 19, even if that child is providing you with otherwise-qualified dependent care assistance.

The law requires that you give the name, address and taxpayer identification number for any person or organization that you use for dependent care assistance on your tax return. If you fail to get this information from any party who provided dependent care assistance to you, you will have to include any amounts you paid through reimbursement under the Dependent Care Assistance Program (or had paid directly by the Dependent Assistance Program) to that party in your gross income for the year. Thus, it is very important that you get this information as soon as possible from those parties providing dependent care assistance to you or your family. It is your responsibility to get this information. The Plan Administrator will not be liable for any additional taxable income to you that might have been avoided if the proper information had been furnished.

BENEFITS DUE TO A MEDICAL CHILD SUPPORT ORDER

Tulare County established Tulare County Flexible Benefits Plan for your benefit as an employee who participates in the plan. Under certain circumstances, your child might be treated as a Participant, also, even if you do not have custody of your child or the child is not your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a decree or order issued by a court that obligates you to provide health benefits for your child. If you incur this type of obligation as a result of a court ordered medical child support order, you must inform the Plan Administrator. The Plan Administrator can provide you with a copy of the Qualified Medical Child Support Order Procedure. This procedure explains the rules that the Plan Administrator must follow to properly handle a QMCSO.

The Plan Administrator will determine if a medical child support order is a Qualified Medical Child Support Order in accordance with the provisions of the Procedure, the Plan Document and Section 609(a)(3) of ERISA. If a medical child support order is found to be a QMCSO, the Plan may be obligated to provide coverage or benefits to the child under any medical benefit offered to you under the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under Tulare County Flexible Benefits Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of thequalifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) The parents become legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. This notice must be provided, in writing, to the Plan Administrator at the address listed at the end of this document.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must make sure that the Plan Administrator is notified, in writing, of the Social Security Administration's determination within 60 days of the date of determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator at the address listed at the end of this document.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to an additional 18 months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent

child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Plan Administrator is notified, in writing, of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at the address listed at the end of this document.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Tulare County Human Resources & Development
Benefits Division
2900 W. Burrel
Visalia, CA 93291
559-733-6266

Tulare County Flexible Benefits Plan

NOTICE OF PRIVACY PRACTICES

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Originally Effective January 1st, 2008, Revised January 1st, 2008.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR PERSONAL AND HEALTH INFORMATION IS IMPORTANT.

Tulare County is committed to protecting the privacy of health information maintained by the health plans it sponsors. This Notice is provided to you as required by the Health Insurance Portability and Accountability Act and the HIPAA Privacy Regulations (collectively, "HIPAA"). It applies to employees and covered dependents enrolled in the Health Insurance Program and Medical Reimbursement Benefit under the Tulare County Flexible Benefits Plan, hereinafter "the Plan".

This Notice describes how the Plan may use health information about you and your covered dependents and when such information may be used and disclosed. This notice also describes how you may have access to this information.

WHAT HEALTH INFORMATION IS COLLECTED?

The Plan considers personal health information to be confidential. The Plan will protect the privacy of that information in accordance with federal and state privacy laws, as well as the Plans' privacy policies. "Health Information" is used to mean information that identifies you and relates to your medical history, such as the health care you receive and or the amounts paid for that care.

Health information subject to the provisions explained in this Notice is information maintained by the Plan. The provisions do not extend to similar information which may be on file with Tulare County as an Employer in its normal course of doing business. The type of health information typically received and maintained by the Plan which is subject to this Notice includes enrollment and claims information, benefit determinations, appeals information, eligibility, and case management information.

SUMMARY OF PERMISSIBLE USES AND DISCLOSURES AND YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION WHICH DO NOT REQUIRE YOUR AUTHORIZATION

In order to provide and administer your benefits, the Plans may use your and disclose your health information in various ways without your express authorization. These include:

- **Payment:** The Plan may use and disclose your health information for purposes of paying for your health care services or to obtain premiums/contributions from you. The Plan may also use and disclose your health information to make determinations about your eligibility for benefit plan coverage, for coordination of benefits with other benefit plans, to perform claims management and collection activities, to review the medical necessity or the appropriateness of the care you received, and to conduct utilization reviews such as pre-authorizations, or reviews, of services.
- **Health Care Operations:** The Plan may use and disclose your health information as necessary to operate and manage their business operations. For example, Tulare County, on behalf of the Plan, has contracts with an outside firm called a "third party administrator" (TPA) to provide administrative services to the Plan. The Plan may use your health information to evaluate the performance of the TPA in managing and providing you with health care benefits. The Plan might use and disclose your health information to contract for reinsurance or to investigate the validity of benefits claims. In addition, the Plan may share your health information with another company that performs certain services, such as billing or compiling information to help the Plan determine how the Plan is doing relative to other plans. Whenever the Plan has such an arrangement, they will have a written confidentiality agreement to ensure that the company that performs these services will protect the privacy of your health information, maintain its confidentiality and limit the uses or further disclosures to the purpose for which the information was disclosed or as required by law.

- **Benefits and Services:** As a part of health care operations, the Plan may use your health information to contact you regarding benefits or services that may be of interest to you, such as benefits that are included in the Plan, your medical treatment, case management and coordination of benefits, recommendations for alternative treatments, therapies, health care providers or settings of care.
- **Employer:** The Plan may disclose certain health information to Tulare County since it is the Employer which sponsors the Plan. Upon a request from Tulare County, the Plan may disclose health information about enrolled employees and their covered dependents to enable the Employer to obtain premium bids from other health plans, or to modify, amend, or terminate the Plan; however, the information the Plan discloses in such situations will not include any information that explicitly identifies individuals. The Plan may disclose to the Employer information on whether you are participating in, enrolled in, or unenrolled from the Plan. The Plan also may disclose health information about you, including information that identifies you, only if it is necessary for the Employer to administer the Plan. For example, Tulare County may need such information to process health benefits claims, to audit or monitor the business operations of the Plans, or to ensure that the Plans are operating effectively and efficiently. The Plan may also disclose information to the Employer with respect to workers' compensation and the Family and Medical Leave Act. The Plan, however, will restrict their use of your information to purposes related only to Plan administration. The Plan prohibits the Employer from using your information for uses unrelated to Plan administration. Under no circumstances will the Plan disclose your health information to the Employer for the purpose of employment-related actions or decisions. The Employer will only disclose the health information it received from the Plan to third parties, such as to consultants or advisors, if the Plan has first obtained a confidentiality agreement from the person or organization which will receive your health information.
- **Disclosures to Friends and Family Involved in Your Care and Payment for Your Care:** The Plans may share information about your health benefits to a person involved in your care such as a family member unless you object. If you have provided a friend or family member with copies of your claim and other relevant identifying information, the Plan will assume that you do not object.
- **Emergencies or Public Need:** The Plan may use or disclose your health information in an emergency or for important public needs. For example, the Plan may share your information with public health officials authorized to investigate and control the spread of diseases. The Plan may have information to prevent or lessen a serious and imminent threat to health or safety.
- **As Required By Law:** The Plan may use or disclose your health information if the Plan is required by law to do so. The Plan will notify you of these uses and disclosures if notice is required by law.
- **Business Associates:** The Plan may share information with service providers who provide administrative services for the Plans.

USES AND DISCLOSURES OF HEALTH INFORMATION WHICH REQUIRE YOUR WRITTEN AUTHORIZATION

Except as otherwise described in this Notice, the Plan, through their third party administrator, will generally obtain your written authorization before using your health information or disclosing it outside the Plan. If you provide the Plan with such a written authorization, you may revoke that authorization at any time, except to the extent that the Plans have already relied on it. To revoke an authorization, write to the Plan Administrator or Privacy Officer.

Access and Control of Your Health Information

The Plan must provide you certain rights with respect to access and control of your health information in your health claims file. You have the following rights to access and control your health information:

- You generally have the right to inspect and copy your health information which the Plan maintains.
- You have the right to request that the Plan amend your protected health information if you believe it is inaccurate or incomplete. You must submit your request in writing to the third party administrator of the Plan in which you are enrolled.
- You have the right to receive from the Plan an accounting of disclosures of protected health information. Your request must be in writing to the Privacy Officer. Many routine disclosures the Plan makes, including disclosures to your Employer for Plan administration, will not be included in the accounting; the accounting will identify only non-routine disclosures.
- You have the right to request further restrictions on the way the Plan uses your health information or shares it with others. The Plan is not required to agree to the restriction you request, but if the Plan does, the Plan will be bound by the agreement until such agreement is revoked by the Plan and you are notified in writing of such revocation.

- You have the right to request that the Plan contact you in a way that is more confidential for you, such as at work instead of at home, if disclosure of your health information could put you in danger and you clearly state that in your request. The Plans will accommodate all reasonable requests.

To Have Someone Act on Your Behalf
You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. This authorization must be in writing and delivered to the Privacy Officer for the Plan.

Special Protections for HIV, Substance Abuse, and Mental Health Information
Special privacy protections may apply to HIV-related information, substance abuse information, and mental health information. Some parts of this Notice may not apply to these types of information.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, please contact the Privacy Officer listed at the end of this notice:

No one will retaliate or take action against you for filing a complaint.

Right to Revise
The Plan may change its privacy practices from time to time. If that happens, the Plan will revise this Notice so you will have an accurate summary of the Plans' practices. The revised Notice will apply to all of your health information. If you received this Notice electronically, you have the right to obtain a paper copy of the Notice. To request a paper copy of this Notice or any revised Notice, please contact the Plan's Privacy Officer. If this Notice is substantially revised, a new Notice will be mailed to you within 60 days.

The Plan is required by law to abide by the terms of the Notice currently in effect.

Contact Information
For further information, please contact the Plans' Privacy Officer:

Monica Emerson, Employee Benefits Manager
Tulare County Human Resources & Development
2900 W. Burrel
Visalia, CA 93291
559-733-6266