City of San Rafael

FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Original Effective Date: January 1, 2000

Amended and Restated: January 1, 2015

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CITY OF SAN RAFAEL FLEXIBLE BENEFIT PLAN

In Brief

The City of San Rafael (the City) Flexible Benefit Plan provides a tax-effective way to pay for certain health care and dependent care expenses. To be covered under this Plan these expenses must not be paid through another source or claimed on your federal tax return. You fund the Accounts and then reimburse yourself through the Accounts for covered expenses on a pre-tax basis.

The use of pre-tax money lets you get more of your health care and dependent care dollars. Additionally, this Flexible Benefit Plan broadens your benefit alternatives since it reimburses you for expenses traditionally excluded from your benefit plans.

You have three Account options:

- **Premium Contribution Account** (if applicable) that allows you to make your share of health care premium contributions on a pre-tax basis.

- **Health Care Expense Account** that reimburses the cost of a wide variety of health care costs not covered by your Health Plans and other covered - but not reimbursed - expenses, like your Plan deductible and co-payments.

- **Dependent Care Expense Account** that reimburses the cost of eligible work-related dependent care expenses.

You may elect to contribute to any one or all of these Accounts or elect to participate in none of them.

There are maximums that you can contribute to each Account. YOU MUST USE THE MONEY PLACED IN YOUR ACCOUNTS WITHIN THE PLAN YEAR OR, UNDER TAX LAW, ANY REMAINING BALANCE WILL BE FORFEITED.

PARTICIPATION IN THE FLEXIBLE BENEFIT PLAN

Eligibility

The Plan is available to any individual on the first of the month following date of employment or reemployment whose relationship with the City is, under common law, that of an employee and who is regularly scheduled to work 22 hours or more per week.

Definition of Dependents

The definition of eligible dependents for purposes of the Health Care Expense Account is the same definition used by the IRS to determine legal dependent status. Note, however, that these dependents do not need to be enrolled in the City's health care coverage plan(s) for their out-of-pocket health care expenses to be covered under the Health Care Reimbursement Account.

The definition of dependents for purposes of the Dependent Care Expense Account is shown in the Dependent Care section of this Summary Plan Description. Please familiarize yourself with these definitions before attempting to estimate your contributions to the Plan.

Plan Participants may elect to cover eligible adult dependent children to age 26, on a pre-tax basis, if permitted under the health plan in which the dependent is enrolled.

Enrollment

In order to participate in the Plan, you must complete an Enrollment Form ***prior*** to your enrollment date. If you do not enroll when you are first eligible to do so, you may not enroll in the Plan until the following January 1 unless you have a Change in Status prior to the following January 1. If you have a Change in Status, you may enroll within 60 days after your Change in Status and your new Enrollment Form will be effective as of the next pay period beginning after the Enrollment Form is filed.

The Enrollment Form that you must fill out in order to participate in the Plan has two purposes. First, this form lists the pre-tax benefits available to you under this Plan. You may select the pre-tax benefits you wish to receive, and for the Health Care and Dependent Care Expense Accounts, you will need to specify the amount of the benefit. Certain highly paid employees may have their elections reduced in order for the Plan to comply with applicable federal laws. If this applies to you, you will be notified.

Second, this form authorizes the City to withhold, from your paycheck, the cost of the benefits you have selected. The advantage to you of participating in the Plan is your ability to pay for benefits with pre-tax dollars rather than post-tax dollars. However, Social Security contributions on your behalf may be decreased as a result of participation in the Plan.

Annual Enrollment

The Plan Year is from January 1 through December 31 of the same calendar year. Prior to each January 1 you will be given the opportunity to change your benefit choices. If you elected contributory coverage under the City's health care plans, your premium contributions will automatically be deducted on a pre-tax basis. If there has been any change in the cost of the health care plans in which you have enrolled, your payroll deductions will be automatically adjusted. If you elected to participate in the Health Care or Dependent Care Expense Account for the prior year and wish to continue in either or both accounts, you must re-enroll by submitting a new enrollment form specifying the amount you want withheld; otherwise deductions will cease.

Changes in Employment Status

In the event your employment status changes, your Expense Account participation will usually be affected.

- Your contributions will stop and your Account balance will be frozen after your final pay period of eligibility in the event you:

  - terminate your employment
  - retire
  - become eligible for long-term disability
  - go on an unpaid leave
  - transfer into an ineligible status, or
  - are temporarily laid-off

- If your contributions are frozen, they can resume upon your again becoming an active employee who is eligible for the Flexible Benefit Plan. These contributions will be at the same rate as before your departure if you return within the same Plan Year. You will have to elect your contribution amount for a new Plan Year's participation.

- If your participation in the Flexible Benefit Plan ceases permanently, you will have 90 days from the end of the Plan Year or your last day of Plan participation whichever is earlier, to submit eligible expenses incurred prior to the date participation ceases under the Plan for reimbursement.

- Changes in employment status may result in your becoming eligible for continuation of health care under COBRA. Please contact the Benefits Administrator with regard to any potential COBRA rights.

  The City reserves the right to modify what is considered a change in your personal situation in accordance with a change in the tax law or an interpretation of that law.

Change in Status

You may change your benefit choices and/or increase or decrease the amount of withholding ONLY (a) at the beginning of a new Plan Year on January 1, or (b) when you have a Change in Status. For purposes of the City of San Rafael Flexible Benefit Plan Status Changes include:

(a) **Special Open Enrollment Rights**. If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30 days after the other coverage ends (or 30 days after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so. The eligible employee also may be subject to additional limitations on the coverage available at that time.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan requires employers that sponsor group health plans to notify employees of any premium assistance that is available to them under a Medicaid or CHIP plan with respect to coverage under the plan.

(b) **Secondary Coverage.** For purposes of benefits paid under this plan the plan shall pay second to any Medicaid, CHIP, or state plan through which the plan participant receives premium assistance or supplemental coverage.

(c) **Legal Marital Status**. Events that change employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation and annulment.

(d) **Number of Dependents**. Events that change the number of employee's Dependents, including following birth, death, adoption and placement for adoption.

(e) **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite, and a change in employment status with consequence that the individual becomes (or ceases to be) eligible under the plan.

(f) **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(g) **Residence.** A change in the place of residence of the employee, spouse or dependent.

(h) **Judgment, Decree or Order**. Compliance with a judgment, decree or order resulting from a divorce, legal separation, annulment or change of custody including a qualified medical child support order.

(i) **Entitlement to Medicare or Medicaid**. Upon becoming entitled to Medicare or Medicaid or loss of such entitlement.

(j) **Change in Coverage of Spouse or Dependent Under Other Employer's Plan**. A change under the plan of the spouse's, former spouse's or dependent's employer, if:

(1) a cafeteria plan or qualified benefit plan of the spouse's, former spouse's or dependent's employer permits its participants to make an election change that would be permitted under these Change in Status rules, or

(2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefits plan of the spouse's, former spouse's or dependent's employer.

(k) **Dependent Care**. In the case of dependent care assistance plan only, if the cost change is imposed by a dependent care provider who is not a relative of the employee.

The revocation and new elections must be on account of and consistent with the Change in Status.

Family and Medical Leave Act

If you are on a leave of absence under FMLA, you may choose to continue coverage under the Plan by making the applicable contributions using one of the following methods as permitted under the rules established by the Administrator and in compliance with FMLA regulations:

(a) Pre-payment made prior to the commencement of the FMLA period on a pre-tax or after-tax basis; or,
(b) Pay-as-you-go basis during the term of the leave on an after-tax basis or pre-tax basis to the extent that the contributions are made from taxable compensation; or,
(c) Catch-up option so long as you and the City have agreed in advance of the coverage period that the City will recoup contributions on a pre-tax basis when you return from FMLA leave.

While on FMLA leave, you may also revoke an existing election for the remainder of the coverage period (i.e., to the end of the Plan Year) or elect to be reinstated upon return from FMLA leave.

Pursuant to IRS regulation, the Plan will reimburse you under the Health Care Expense Account the full amount of the elected coverage so long as your coverage under the Health Care Expense Account does not terminate while you are on FMLA leave. If it does, the Plan will reimburse you only for the period the coverage was in effect.

For purposes of the Dependent Care Expense Account while on FMLA leave, you are entitled to make election changes due to changes in status or revoke election to the same extent employees taking non-FMLA leave are permitted to revoke elections under a cafeteria plan.

Where FMLA leave spans two cafeteria Plan Years, you may only make an election for the remainder of the Plan Year in which the FMLA leave begins.

Consolidated Omnibus Budget Reconciliation Act of 1985

Notwithstanding anything in the Plan to the contrary, to the extent required by Code Section 4980B and IRS Regulations there under (COBRA), a qualified beneficiary who would lose coverage under a health care Plan upon the occurrence of a qualifying event (as defined in Code Section 4980(f)(3)) shall be permitted to continue coverage under the Plan by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with COBRA. Qualified beneficiaries who have elected to participate in the Health Care Expense Account who would lose coverage under the Health Care Expense Account upon the occurrence of a qualifying event (as defined in Code Section 4980B(a)(3) shall be permitted to continue coverage under the Health Care Expense Account in the event that the benefit available there under is equal to or exceeds the potential COBRA premium due for the Health Care Expense Account for the remainder of this Plan's Plan Year. The City shall provide notice to each covered employee and his spouse of their rights under COBRA in accordance with applicable law. Please refer to page 14 for a full description of your COBRA rights.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting condition exclusions applied in the Plan upon return from service. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Contributions

It is important that you estimate carefully how much you will put into the Health Care and Dependent Care Expense Accounts since unused money is forfeited at Plan Year end. Once elected, your contribution level cannot be changed during the Plan Year unless you have a change in your personal situation as discussed under Change in Status.

You should also be aware that the amounts eligible for contribution to these Accounts are within levels prescribed by tax law. Thus, allowable contributions can change in response to modifications in that law.

Any eligible expenses incurred during the Plan Year or the portion of the Plan Year in which you participate can be submitted for reimbursement. You will have 90 days from the end of the Plan Year or your last day of Plan participation, whichever is earlier, to submit claims. After that time, you will forfeit any unused money in your Health Care and Dependent Care Expense Accounts.

Forfeitures

Any money left in the Expense Accounts after all expenses for the Plan Year have been submitted is, under tax law, forfeited. You cannot transfer money between the Accounts even if you have money remaining in one Account and outstanding expenses in the other. Forfeitures are used by the City to help cover the Plan's administrative costs.

The forfeiture of unused dollars is the reason why it is imperative that you estimate your costs carefully before deciding on your Expense Account contributions. Remember, your contribution level must remain in effect for an entire Plan Year unless you have a qualifying Change in Status.

PLAN DETAILS

Premium Contribution Account (if applicable)

As an eligible employee of the City, you will have certain required employee contributions toward health care premiums deducted from your paycheck on a pre-tax basis thus reducing taxable compensation and increasing your take home pay. The reduction in your salary as a result of your participation in the Plan will not affect other City-provided benefits, which are based on compensation. However, Social Security contributions may be decreased as a result of your decreased taxable compensation. Your written declination of participation must be received by the Benefits Administrator prior to the beginning of the new Plan Year.

Health Care Expense Account

Each Plan Year, you can contribute up to $2,550 to this Account. Your contributions can be used to pay for a wide variety of health care expenses defined as "deductible" by tax law. The expenses must be incurred by either you or your dependents who meet the eligibility requirements under your health plan. In general, this Account makes reimbursement for:

- expenses covered, but not paid, by your health plans, including your Plan's deductibles, co-payments, coinsurance, amounts over usual and prevailing charges, and penalties incurred by your failure to use cost-containment provisions; and,

- non-covered health care expenses.

  However, you may NOT be reimbursed under the Health Care Expense Account for premiums paid for other health plan coverage, including premiums paid for health care coverage under a plan maintained by your spouse's employer.

  Health care expenses reimbursed under this Account cannot be paid from any other source. For example, if your spouse also participates in a Health Care Expense Account, the expenses will only be eligible for reimbursement under one of the accounts. Also, they cannot be claimed as a deduction on your federal tax return; however, this may not hold true for state and local taxes.

  For information on health continuation coverage under COBRA for health care coverage and the Health Care Expense Account, see the initial COBRA notification you received when you became an employee of the City, or contact the Benefits Administrator.

Health Care Expense Account

Partial List of
Deductible Medical Expenses
(IRC Section 213)

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped*
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental treatment
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription)
- Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices*
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment-related physicals) and clinical care
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy
- Surgical fees
- Therapy treatments*
- Vaccinations
- X-rays

*if prescribed for a particular ailment or medical condition; provider letter required

- *Any of these expenses which are for cosmetic purposes only will not be deductible for income tax purposes and therefore are not eligible expenses under the Health Care Expense Account.*

IRC Section 106(f)

- As of January 1, 2011, the new IRC Section 106(f) definition of covered medicines or drugs provides favorable tax treatment for:

  a. Prescribed drugs
  b. Prescribed drugs (available over-the-counter but prescribed by a physician); and,
  c. Insulin

- A full list of eligible expenses can be found on TLC's Administrators' website www.myrsc.com.

Dependent Care Expense Account

The Dependent Care Expense Account is designed to help you pay for child care services for a child who is under age 13 or care for a disabled spouse or dependent when those services make it possible for you (or you and your spouse if you are married and/or your spouse is not disabled or a full-time student) to work. Any type of dependent care that you could legally claim if you were filing for a credit on your federal income taxes is eligible for reimbursement under the Dependent Care Expense Account. To be eligible for this benefit, you (*and* your spouse, if you are married and your spouse is not disabled or a full-time student) must be at work during the time your eligible dependent(s) is receiving care. The maximum amount you may elect to withhold from your salary for Dependent Care Expenses is $5,000 per Plan Year.

You qualify for this benefit if:

(a) you are a single parent; or,

(b) you have a working spouse; or,

(c) your spouse is a full-time student for at least five months during the year while you are working; or,

(d) your spouse is disabled and unable to provide for one's own care.

Expenses may be reimbursed for the following types of services:

(a) inside or outside your home by anyone *other than*:

(1) your spouse;
(2) someone who is your dependent for income tax purposes;
(3) one of your children under age 19; or

(b) in a dependent care center or a child care center (if the center cares for more than six (6) children, it must comply with all applicable state and local regulations); or,

(c) by a housekeeper whose services include, in part, providing care for an eligible dependent.

Expenses which may not be reimbursed under the Dependent Care Expense Account are:

(a) the cost of transportation between your home and your dependent care provider; or,

(b) any amount paid for services outside your home at a camp where your child or disabled spouse or dependent stays overnight; or,

(c) amounts paid to provide food, clothing or education.

- If both you and your spouse work and both participate in Dependent Care Expense Accounts, your combined contributions must fall within the maximum limits. And, if you are filing your taxes separately, your pre-tax contributions can be no more than half of your total allowable maximum contribution.

- If during a calendar year, your dependent care expenses exceed the applicable dollar limit, amounts reimbursed above the limit will be taxable.

Eligible Dependent Care Expenses -- At a Glance

Reimbursable through the Dependent Care Expense Account are work-related expenses for:

- daycare centers and day camps
- total cost of sending your child to school if your child is in a grade below first grade and the amount paid for schooling is not separated from the cost of care
- cost of daycare (excluding tuition) if your child is in first grade or higher
- dependent care centers, providing daycare not residential care, for dependent adults
- individuals, other than your dependents or children under age 19, who provide care for your dependents who are under age 13 or who otherwise are qualifying persons, in or outside your home
- cost of household services related to the care of a dependent, and
- Social Security taxes or other taxes paid on behalf of a provider of dependent care.

Tax Credit Alternative

Payments to you under the Dependent Care Expense Account for qualifying dependent care expenses will not be taxable income to you. HOWEVER, IN SOME CASES IT MAY BE MORE TO YOUR BENEFIT TO CLAIM THE DEPENDENT CARE CREDIT ON YOUR INCOME TAX RETURN THAN FOR YOU TO HAVE THOSE EXPENSES REIMBURSED UNDER THE DEPENDENT CARE EXPENSE ACCOUNT. Under the federal tax rules, any amount deducted from your salary for dependent care assistance reduces dollar for dollar from your salary for dependent care expenses ($3,000 if one dependent, or $6,000 if two or more dependents) which may be taken into account for purposes of the dependent care tax credit. For example, if you have one dependent and have $3,000 or more of child care expenses reimbursed under the Dependent Care Expense Account, you will not be entitled to a dependent care tax credit even if your dependent care expenses exceed that amount withheld from your pay. You have to determine which approach is best for your particular circumstances. Your tax advisor should be contacted in this regard.

TAX SAVINGS COMPARISON		
Dependent Care Expense Account (DCEA) vs. Tax Credit (TC)		
	More Favorable Method	
Adjusted Gross Income	**One Dependent**	**More Than One Dependent**
If you are married...		
$10,000	DCEA	DCEA
12,500	DCEA	DCEA
15,000	TC	DCEA
17,500	TC	DCEA
20,000	TC	Equal
25,000	DCEA	DCEA
30,000 +	DCEA	DCEA
If you are single...		
$10,000	DCEA	DCEA
12,500	TC	DCEA
15,000	TC	DCEA
17,500	TC	TC
20,000	TC	TC
25,000	DCEA	DCEA
30,000 +	DCEA	DCEA

If you are participating in the Dependent Care Expense Account, you cannot take a tax credit for any amounts reimbursed through the Plan. You can, however, take a tax credit for amounts in excess of your Expense Account contributions up to allowable limits under tax law.

Claims Submission for Health Care and Dependent Care Expense Accounts

Reimbursements from Expense Accounts are made directly to you by the Contract Administrator.

The following additional guidelines apply to reimbursement requests:

(a) You must specify the services for which you are requesting reimbursement.

(b) You must attach copies of your bill, over-the-counter medicine or drug receipt, invoice, insurance benefit payment statement (Explanation of Benefits) showing you have paid or have been billed for the services; or for dependent care expenses, you must sign the claim form, verifying the expenses.

(c) No reimbursement can be made for dependent care services or health care services performed *before* you become a participant in the Plan.

(d) No dependent care reimbursement shall at any time exceed the amount withheld from your pay as of the date of such reimbursement, less prior reimbursements. Health care reimbursements may not exceed, at any time, the total amount you have elected to have withheld from your pay during a Plan Year for health care reimbursements, less prior reimbursements.

(e) Amounts withheld from your pay during a calendar year for dependent care expenses or health care expenses may only be used to reimburse you for dependent care services performed or health care expenses incurred during the same Plan Year. *Unused amounts cannot be carried over to future years.* Furthermore, amounts withheld from your paycheck to pay for dependent care cannot be used to pay for health care expenses, and vice versa.

(f) All reimbursement requests for a Plan Year must be submitted within 90 days of the end of that year or 90 days after the day your participation under this Plan ends, whichever is earlier.

(g) FEDERAL LAW REQUIRES THAT ANY AMOUNTS WHICH ARE WITHHELD FROM YOUR PAY FOR DEPENDENT CARE REIMBURSEMENTS OR HEALTH CARE REIMBURSEMENTS AND WHICH ARE NOT USED IN THE SAME PLAN YEAR MUST BE FORFEITED.

(h) If you do not provide the name, address and, if applicable, the taxpayer identification number of your dependent care provider, you will be required to report the amount of your pre-tax dependent care reimbursement as taxable income.

(i) The amount of your pre-tax dependent care reimbursement must be reported on your Form W-2. This is solely for purposes of reporting to the IRS and does not mean that this amount is taxable. Each year, on or before January 31, the City will provide you with a written statement showing the amounts paid under the Plan in the previous calendar year.

Claims Appeal Procedure

In the event that your claim is denied, in whole or in part, the Administrator will notify you within 30 days of receipt of such claim. Should the Administrator face delays not of its own creation, the Administrator may extend the determination period an additional 15 days only if it notifies you of the delay prior to the exhaustion of the initial 30 day period. If the delay occurs as a result of deficient information submitted by you, the extension notice must describe the required information necessary for determination. You will have a minimum of 45 days to submit the requested information to the Administrator. The notice of a denial of a claim shall be written in a manner calculated to be understood by you and shall set forth:

(a) The specific reason for the denial;

(b) Specific references to the pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and,

(d) An explanation of the Plan's claims procedure.

(e) Your right to bring a civil action under ERISA Section 502(a)

Within 180 days after the receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(a) Request a review upon written notice to the Administrator;

(b) Review pertinent documents; and,

(c) Submit issues and comments in writing.

Review and Decision

Full and Fair Review. Within 60 days after receipt of a request for review, the Administrator, as Plan Fiduciary, shall take into account all comments, documents and other information submitted by you without regard to whether the information submitted with the original claim and without deference to the original determination.

Decision. The decision of the Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal.

Second Appeal. Should you receive an adverse determination of the appeal, you have the right to file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of response to the second appeal shall be made in accordance with the same time guidelines as those outlined for the first appeal.

Note: ***Claims for Benefits from Health Care Providers***. If you have elected health care coverage, you should follow the claim procedures for the particular plan in making any claims for benefits under this plan. For further information, see the Summary Plan Description for your health care plans.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA - Introduction

You are receiving this notice because you have recently become covered under a group health plan (the 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 and to other members of your family who are covered under the Plan 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 review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health 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 the qualifying 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:

- Your hours of employment are reduced, or
- 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:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- 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:

- The parent-employee dies;
    - The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- 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. Your notice must provide the type of qualifying event, the date of the qualifying event and the name and address of the employee, spouse or dependent who underwent the qualifying event.

You must provide this notice to:

City Name:	City of San Rafael
Address:	1400 Fifth Avenue, Suite 210, San Rafael, California 94915-1560
Phone Number:	(415) 485-3063
Department:	Human Resources

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 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 provide notice to us of receipt of a determination by Social Security of total disability within 60 days of the date of the notice, the name of the qualified beneficiary who has become disabled, a copy of the determination letter and the original date of disability.

You must provide this notice to:

City Name:	City of San Rafael
Address:	1400 Fifth Avenue, Suite 210, San Rafael, California 94915-1560
Phone Number:	(415) 485-3063
Department:	Human Resources

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 18 additional 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 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other law 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 address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Plan Name:	City of San Rafael Flexible Benefit Plan
City Name:	City of San Rafael
Address:	1400 Fifth Avenue, Suite 210, San Rafael, California 94915-1560
Phone Number:	(415) 485-3063

YOUR RIGHTS UNDER ERISA

As a participant in the Flexible Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor, which is available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, (if you request it before losing coverage) or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement, about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other ERISA Information

The Plan Name:	City of San Rafael Flexible Benefit Plan
The Plan Number:	501
The Plan Year:	January 1 through December 31
The Plan Sponsor and Plan Administrator:	City of San Rafael
The City's Tax Identification Number:	94-6000424
The Agent for Service of Process:	City of San Rafael
Administrative Services for IRC Section 125 Plan:	TLC Administrators 3340 Walnut Avenue, Suite 290 Fremont, CA 94538 (510) 795-0103
Type of Plan:	IRS Section 125 Plan with spending accounts
The City's Official Name, Address, and Phone Number:	City of San Rafael 1400 Fifth Avenue, Suite 210 San Rafael, California 94915-1560 (415) 485-3063

NOTICE

Controlling Provisions

The information contained in this Summary Plan Description is only a general discussion of the relevant provisions of the Plan found in the official Plan Document. In all events, the provisions of the official Plan Document shall control with regard to all matters concerning the administration and operation of the Plan. The official Plan Document is available for your review at the City's headquarters.

Amendment and Termination

City of San Rafael intends to maintain the Plan indefinitely but is under no obligation to continue the Plan and can terminate the Plan without liability by providing written notice to all then current Plan participants. In terminating or amending the Plan, the City cannot retroactively reduce the benefits to which you are entitled prior to the termination or amendment.

City of San Rafael intends to maintain the Plan as a tax-qualified plan under the Internal Revenue Code. In order to obtain and/or maintain such status, the City may be required to make subsequent amendments to the Plan. Some amendments might be made on a retroactive basis.

Privacy of Information

In the administration of this Plan, the City or of one of its Business Associates may be required to use or disclose protected information for purposes of paying or causing to be paid benefits under this Plan. The City has established the following policy regarding the use and disclosure of protected information. The City hereby agrees to:

- Not use or disclose protected health information other than as permitted or required by the Plan Document or by law;
- Ensure that any agents to whom it provides protected information agrees to the same restrictions and conditions that apply to the Plan sponsor;
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor;
- Report to the group health plan any use or disclosure of protected health information inconsistent with Plan provisions;
- Make protected health information available as required under other privacy rule provisions;
- Make internal practices and records regarding protected information available to the HHS Secretary.
- Where feasible, return or destroy all protected information received from the group health plan that is no longer needed for the purpose for which disclosure was made.

Please refer to the Plan's Notice of Privacy Practices for details.