RIVERSIDE COUNTY TRANSPORTATION COMMISSION

DATE:	September 10, 2008
TO:	Executive Committee
FROM:	Michele Cisneros, Accounting and Human Resources Manager
THROUGH:	Anne Mayer, Executive Director
SUBJECT:	Flexible Benefits Plan Amendment

STAFF RECOMMENDATION:

This item is for the Committee to:

1) Approve the revision to the Flexible Benefits Plan;
2) Approve the revision to the Flexible Benefits Plan "Frequently Asked Questions" for distribution to employees; and
3) Adopt Resolution No. 08-022, *"Resolution of the Riverside County Transportation Commission Amending the Flexible Benefits Plan".*

BACKGROUND INFORMATION:

On September 11, 2002, the Executive Committee approved the establishment of a Section 125 Premium Conversion Plan (Plan) to provide eligible Commission employees with a means of purchasing certain health benefits in a tax-effective manner. The Plan would also qualify as a cafeteria plan under Section 125 of the Internal Revenue Code (IRC) whereby benefits that the employee elects to receive under the Plan are eligible for exclusion from the employee's income for federal tax income purposes. As a result of this plan, employees were allowed to make premium payments for health coverage with pre-tax deductions.

On June 14, 2006, a restatement of the Flexible Benefits Plan was required in order to be in compliance with the IRC, Employee Retirement Income Security Act of 1974 (ERISA), and Health Insurance Portability and Accountability Act of 1996 (HIPAA). On August 3, 2007, the Internal Revenue Service (IRS) has proposed new regulations. The proposed new regulations are effective for plan years beginning on or after January 1, 2009.

Staff has requested that legal counsel review the current Plan and determine what revisions were necessary to bring the Plan in compliance with the proposed new regulations. Legal counsel has identified the following necessary changes and has recommended amendments to the Plan:

- Health coverage for non-dependent individuals – The IRS has confirmed that a cafeteria plan may provide health and medical benefits to an individual who is not the legal dependent or qualifying relative of the participating employee and which is often the case with most domestic partner relationships.

- Participant elections – The new regulation has provided comprehensive guidance on how elections should be administered and when elections may be changed mid-year. The regulation also confirms that the plan administrator may use electronic media such as email and the intranet for sending and receiving enrollment material and other plan-related material.

- Reimbursement (substantiation of expenses) – The Plan is prohibited from advancing funds from a flexible spending account or reimbursing expenses that were not properly substantiated by a receipt or invoice from a third party service provider.

- Period of coverage – The regulations define what is a period of coverage for purposes of determining plan benefits.

There is no cost to the Commission for implementing these changes to the Plan.

Attachments:
1) Resolution No. 08-022
2) Flexible Benefits Plan Amendment No. 1
3) Flexible Benefits Plan "Frequently Asked Questions"

RESOLUTION NO. 08-022

RESOLUTION OF THE
RIVERSIDE COUNTY TRANSPORTATION COMMISSION
REGARDING THE AMENDED FLEXIBLE BENEFITS PLAN

WHEREAS, the Riverside County Transportation Commission (the "Commission") currently retains the authority to add, delete or otherwise modify the Commission's policies and procedures; and

WHEREAS, the Commission has granted the Executive Committee the authority to add, delete or otherwise modify the Commission's policies and procedures; and

WHEREAS, the Commission previously established the Riverside County Transportation Commission Flexible Benefits Plan on September 11, 2002 ("Flexible Benefits Plan") to allow participating employees the opportunity to contribute salary reduction amounts on a pretax basis for the purchase of benefits made available under the Flexible Benefits Plan; and

WHEREAS, the Commission desires to adopt changes to the Flexible Benefits Plan as required under regulations issued by the Internal Revenue Service applicable to "cafeteria-benefit plans" under Section 125 of the Internal Revenue Code effective for plan years beginning on or after January 1, 2009; and

WHEREAS, the Commission has been advised by the Commission's attorney, Best Best & Krieger LLP, that it will be necessary to formally amend the Commission's Flexible Benefits Plan to adopt such provisions; and

WHEREAS, the proposed form of amendment to the Flexible Benefits Plan, which said amendment incorporate the necessary regulatory changes, has been submitted to the Executive Committee for consideration and action

NOW, THEREFORE, the Riverside County Transportation Commission does hereby resolve as follows:

Section 1. The Riverside County Transportation Commission hereby approves and adopts Amendment No. 1 to the Flexible Benefits Plan, as heretofore discussed, to be effective September 10, 2008.

Section 2. The Riverside County Transportation Commission hereby authorizes the Commission's Chair to execute said amendment on behalf of the Commission.

APPROVED AND ADOPTED this 10th day of September, 2008.

Jeff Stone, Chair
Riverside County Transportation Commission

ATTEST:

Jennifer Harmon
Clerk of the Board

RIVERSIDE COUNTY TRANSPORTATION COMMISSION

FLEXIBLE BENEFITS PLAN

AMENDMENT NO. 1

1. RIVERSIDE COUNTY TRANSPORTATION COMMISSION (the "Employer") established the RIVERSIDE COUNTY TRANSPORTATION COMMISSION FLEXIBLE BENEFITS PLAN (the "Plan") effective September 11, 2002.

2. It is necessary to amend the Plan in order to comply with proposed regulations issued by the Internal Revenue Code on August 3, 2007 concerning the administration and operation of Section 125 cafeteria plans.

3. Section 13.2 of the Plan provides that the employer reserves the rights to amend the Plan at any time.

NOW, THEREFORE, Employer hereby amends the Plan, effective September 10, 2008.

ARTICLE I
TITLE AND PURPOSE

This Plan shall be known as the RIVERSIDE COUNTY TRANSPORTATION COMMISSION FLEXIBLE BENEFITS PLAN (the "Plan"). The purpose of the Plan is to furnish to eligible employees choices among certain Benefits provided by the Employer, so that employees may receive Benefits that best meet their individual needs. The Plan is intended to provide benefits in accordance with Sections 125, 105 and 129 of the Internal Revenue Code, as amended, and the Regulations issued thereunder, so that the Benefits that an Employee elects to receive under the Plan are eligible for exclusion from the Employee's income for Federal Income Tax purposes.

The Plan is also intended to qualify under Sections 105(b) and 129(d) of the Internal Revenue Code with regard to the written documentation requirements for self-funded medical reimbursement and dependent care assistance plans.

ARTICLE II
COMPONENT PLANS

The Benefits offered under this Plan are provided through separate Component Plans which are set forth in separate plan documents, group insurance policies or administrative service contracts and are incorporated herein and identified in Schedule "A" attached hereto. Notwithstanding, the provisions of the separate Medical Reimbursement Plan and Dependent Care Plan Component Plans are set forth in this Plan document.

ARTICLE III
DEFINITIONS

The following words and phrases, when used herein, shall have the following meanings, unless a different meaning is clearly required by the context:

3.1 Administrator. "Administrator" shall mean the Employer or any person or entity appointed by the Employer to administer this Plan on its behalf, as provided in Article XI.

3.2 Benefit. "Benefit" shall mean any of the qualified benefits which may be purchased under this Plan. "Benefits" shall also mean any amounts paid to a Participant in the Plan as reimbursement under the Medical Reimbursement Plan (see Article VIII) or the Dependent Care Plan (see Article VII).

3.3 Code. "Code" shall mean the Internal Revenue Code of 1986, as amended. References to any section of the Code include references to any comparable or succeeding provision of any legislation which amends, supplements or replaces such section.

3.4 Component Plan. "Component Plan" shall mean any plan offering Benefits available under this Plan, as set forth in the separate plan documents, except for the Medical Reimbursement Plan (see Article VIII) and the Dependent Care Plan (see Article VII).

3.5 Dependent. "Dependent" includes the spouse or dependent of a Participant who is eligible to receive benefits under a Component Plan and who is specifically defined as a legal dependent under Section 152 of the Code. Dependent shall also mean, as to health benefits offered under the Plan, a dependent eligible under Code Section 152, determined without regard to Code Section 152(b)(1), (b)(2), or (d)(1)(B).

Notwithstanding the preceding, if Component Plan permits a Participant to cover an individual other than the Participant's spouse or Dependent (including a Participant's registered domestic partner as recognized by the State of California), the term Dependent as used throughout the Plan document shall also include such individual provided the benefit is treated as a taxable benefit in accordance with Section 6.7.

3.6 Effective Date. "Effective Date" shall mean the date this Plan first became effective, which is September 11, 2002.

3.7 Eligible Dependent Care Expense. "Eligible Dependent Care Expense" means substantiated expenses incurred by the Participant during the Plan Year or grace period described in Section 7.7 for Qualifying Dependent Care Services or for the cost of sending a child of the Participant to a Qualifying Day Care Center. Expenses relating to nonrefundable fees charged by a Qualified Day Care Center shall not be eligible for reimbursement unless the child care services directly related to the fee are provided.

3.8 Eligible Medical Care Expense. "Eligible Medical Care Expense" means substantiated expenses submitted by the Participant for reimbursement of medical and/or dental services incurred by the Participant, or the Participant's Spouse during the Plan Year or during the grace period defined in Section 8.7. "Eligible Medical Care Expenses" shall include amounts

paid for prescription and over-the-counter drugs and medicines, and such other expenses which are not covered by insurance and which are permitted to be reimbursed under a medical flexible spending account pursuant to Section 213(d) of the Code, as amended, or as authorized by the IRS from time to time. Eligible Medical Care Expense does not include premiums paid on accident or health insurance or premiums on long-term care insurance, whether or not such insurance is paid for by the Employer.

3.9 Employee. "Employee" shall mean all regular and probationary employees of the Employer and, to the extent necessary, former employees who are entitled to receive benefit payments under this Plan. Temporary or contract employees are not eligible to participate. "Employee" shall also mean any individual who is treated as employed by a single employer under Sections 414(b), (c) and (m) of the Code. "Employee" shall not include any self-employed individual described in Section 401(c) of the Code.

3.10 Employer. "Employer" shall mean RIVERSIDE COUNTY TRANSPORTATION COMMISSION, any other organization which adopts this Plan with the consent of Employer, and any successor of such Employer.

3.11 Entry Date. "Entry Date" shall mean, for all newly hired Employees, the next payroll period immediately following completion and submission of the enrollment forms. In all other cases, the "Entry Date" shall mean the first day of each Plan Year.

3.12 ERISA. "ERISA" shall mean the Employee Retirement Income Security Act of 1974.

3.13 FMLA. "FMLA" shall mean the Family Medical Leave Act of 1993, as amended and including all regulations issued thereunder.

3.14 Highly Compensated Participant. "Highly Compensated Participant" shall mean a Participant who is (i) a director of the Employer, (ii) highly compensated, or (iii) a spouse or dependent of a Highly Compensated Participant. The classification of a Participant as highly compensated for this purpose shall be made on the basis of the facts and circumstances of each case.

3.15 Key Employee. "Key Employee" means any Employee defined as such in Section 416(i)(1) of the Code and the regulations issued thereunder.

3.16 Leave of Absence. "Leave of Absence" shall mean any absence of an Employee which is authorized by the Employer under the Employer's personnel policies, including any leave designated as FMLA Leave. Additionally, an Employee shall be subject to such rights and benefits for Family or Medical Leave, as defined in the Family and Medical Leave Act of 1993, as are provided under the Act, and the California Family Rights Act of 1991.

3.17 Open Enrollment Period. "Open Enrollment Period" shall mean the period beginning at least thirty (30) days before the beginning of the next Plan Year and ending on any date preceding the commencement of the Plan Year, as determined by the Administrator. For a new Employee, "Open Enrollment Period" shall mean the period beginning the Employee's effective date of employment and ending 31 days later.

3.18 Participant. "Participant" shall mean an Employee who becomes enrolled in the Plan pursuant to Article IV. "Participant" shall also mean a former Employee who elects to continue health coverage under the Plan.

3.19 Plan. "Plan" shall mean the RIVERSIDE COUNTY TRANSPORTATION COMMISSION FLEXIBLE BENEFITS PLAN, set forth herein, including all subsequent amendments and modifications hereto.

3.20 Plan Year. "Plan Year" shall mean the twelve (12) consecutive month period commencing July 1 and ending on June 30. Effective January 1, 2007, the Plan Year shall commence on January 1 and end on December 31.

3.21 Qualifying Day Care Center. "Qualifying Day Care Center" means a day care center which –

(a) provides full-time or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the Eligible Employee's taxable year, and

(b) which complies with all applicable laws and regulations of the state and town, city or village in which it is located; and receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

3.22 Qualifying Individual. "Qualifying Individual" means a Dependent of the Participant, as defined in Code Section 152(a)(1), who is under the age of 13. "Qualifying Individual" shall also mean a Dependent or Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one-half of the Plan Year, provided such individual regularly spends at least eight hours a day in the Participant's home during such period.

3.23 Qualifying Dependent Care Services. "Qualifying Dependent Care Services" or "Qualifying Services" means services performed to enable a Participant or his Spouse to remain gainfully employed and which are relevant to the care of a Qualifying Individual. Qualifying Services may be performed either in the home or outside the home of the Participant. Such an expense shall be an Eligible Dependent Care Expense only if it is payable to a person who is not (1) a Dependent of the Participant; (2) the Participant's Spouse; or (3) a child of the Participant under the age of 19 as of the close of the Plan Year in which the services are rendered.

3.24 Salary Reduction. "Salary Reduction" shall mean the amounts paid into the Plan pursuant to elections made by the Participant to reduce his or her compensation for the purchase of Benefits elected by the Participant.

3.25 Short Plan Year. "Short Plan Year" shall mean a Plan Year which is less than twelve (12) months and which ends on the last day of the Plan Year. This Short Plan Year shall arise only in the following circumstances: (i) the initial Plan Year did not begin on July 1; or (ii) the Employer changes the Plan Year for a valid business purpose resulting in a Short Plan

Year. In the event that a Short Plan Year is in effect, all references to "Plan Year" shall be replaced by "Short Plan Year" in all instances where it is appropriate.

3.26 Spouse. "Spouse" means the person to whom the Participant is legally married but shall not include an individually legally separated from a Participant under a decree of legal separation. Notwithstanding, a Participant's registered domestic partner shall be entitled to and receive the same rights and coverage attributable to medical and health benefits offered under the Plan pursuant to the California Domestic Partner Rights and Responsibilities Act of 2003.

3.27 Student. "Student" means an individual who during each of five calendar months during a Plan Year is enrolled as a full-time student at an "educational institution." For this purpose, "educational institution" means any institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

3.28 Uniformed Services. "Uniformed Services" shall mean the Armed Forces, the Armed National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

3.29 Period of Coverage. "Period of Coverage" generally means the Plan Year beginning on January 1 and ending on December 31. A Participant's Period of Coverage may be less than 12 months if a new Participant enters the Plan during the year or a Participant completes a permitted election change in accordance with Article V. A Participant's Period of Coverage shall also include continuation coverage elected by a terminated Participant or Qualified Beneficiary. A Participant's Period of Coverage under the medical spending account or dependent care spending account shall not be less than twelve (12) months unless the Plan Year is Short Plan Year.

ARTICLE IV
ELIGIBILITY AND PARTICIPATION

4.1 Eligibility. Each Employee shall be eligible to participate in the Plan as of his or her Entry Date.

4.2 Participation. An Employee may become a Participant by completing and executing an election form and Salary Reduction Agreement and by providing such other information as is reasonably required by the Employer as a condition of such participation. A Participant's election to participate in the Plan shall continue to be valid until expressly revoked or altered, as set forth in Article V. The Administrator shall continue to make Salary Reductions and the Participant shall be deemed to have selected the Benefits previously elected by Participant in subsequent Plan Years consistent with the Participant's most recent election form.

4.3 Recommencement of Participation. A former active Participant may recommence participation in the Plan on his date of reemployment as an eligible Employee. However, a reemployed former active Participant may not make a new election to participate in a

medical spending account and/or dependent care spending account which is effective during the same Plan Year in which he or she separated from service with the Employer. If a former active Participant is rehired by the Employer within 30 days of his or her date of termination, such Participant shall not be permitted to submit a new election and his or her prior election shall be reinstated for the remainder of the Plan Year.

Any employee who returns to active employment within ninety (90) days of completing a period of absence from employment for duty in the Uniformed Services shall reenter the Plan upon reemployment. A Participant whose health coverage under the Plan is terminated on account of his being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical spending account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

4.4 Leave of Absence. An Employee shall not be disqualified from participating in the Plan during the period in which the Employee is on an authorized Leave of Absence; however, that Employee shall continue to have an employment relationship with the Employer and Employee shall pay the required costs of coverage as provided in Section 6.2.

A Participant who takes an unpaid leave of absence under FMLA ("FMLA Leave") shall pay the required costs of coverage as provided in Section 6.2; however, the Employee may revoke his or her election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may then elect to be immediately reinstated in the Plan, on the same terms that applied to the Participant prior to the FMLA Leave, and with such other rights to revoke or change elections as are provided to the Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Participants.

4.5 Cessation of Participation. An Employee shall cease to be a Participant under this Plan and therefore, under each Component Plan, as of the earliest of:

(a) the date on which the Participant separates from service with the Employer; or

(b) the date on which the Administrator, on a consistent and uniform basis, deems the Participant has failed to make the required premium payments, including the Salary Reduction, for the elected benefits, as provided in Section 4.6; or

(c) the date on which the Participant is not eligible to participate in any of the Component Plans for which he or she wishes to make an election; or

(d) the date on which the Participant dies; or

(e) the date on which the Plan terminates.

4.6 Cessation of Required Contributions. A Participant's election to participate in the Plan may be terminated in accordance with Subsection 4.5(b) if the Participant fails to make the required premium payments with respect to the Benefit. In such case, that individual may not make a new benefit election for the remaining portion of the Plan Year.

4.7 Eligibility Under Component Plans. The eligibility of a Participant under a Component Plan shall be the same as set forth in this Article, unless otherwise specified in the Component Plan under which a Participant has elected to receive benefits. Each Component Plan may provide more rigorous eligibility requirements which may cause a Participant to be ineligible to participate in a particular Component Plan, but continue to be eligible to participate in this Plan.

ARTICLE V
ELECTIONS AND PROCEDURES

5.1 Initial Election. Prior to the annual Entry Date (or mid-year Entry Date for newly hired Employees), there shall be an Open Enrollment Period during which the Employee may elect to participate in this Plan. The Administrator shall provide each Employee during each Open Enrollment Period with an election form and Salary Reduction Agreement which shall include, at a minimum, the following information:

(a) that the election form shall be completed and returned to the Administrator during the Open Enrollment Period; and

(b) that the election shall be effective on the Entry Date and continue in effect until the last day of the Plan Year for which the election is made, or until the Participant provides the Administrator with a new election form modifying or terminating his or her existing election; and

(c) that the election shall be irrevocable, unless the Participant is entitled to change his or her election as provided in this Article V; and

(d) that the Participant's Salary Reduction shall be considered as employer contributions used to pay for Benefits under the Plan.

5.2 Salary Reduction. Each Participant shall authorize the Employer to reduce his compensation by the amount needed for the purchase of Benefits, as elected by that Participant. The Administrator, may, in its discretion, establish a limit on the amount of Salary Reductions which a Participant may elect for the Plan Year, for purposes of complying with the nondiscrimination requirements of Article X. Salary Reductions shall be contributed to the Plan by the Employer on behalf of a Participant on a level and pro rata basis for each payroll period. In the event that an Employee ceases to be a Participant in this Plan, a Participant shall have no obligation to continue to make payments equal to the Salary Reduction.

5.3 Election of Benefits. Each Participant shall submit to the Employer on the election form provided by the Plan Administrator his or her election as to the Benefits to be

provided by the Employer and the portion of his or her Salary Reductions which are to be applied to provide each Benefit.

5.4 Participant Makes Incorrect Election. If a Participant does not elect the correct amount under his or her Salary Reduction to pay for coverage of the Benefits elected under the Plan, the Administrator is authorized to increase or decrease a Participant's election by the amount necessary to provide the Participant's elected coverage under the Plan.

5.5 Cost of Coverage Increased or Decreased. If the cost of any Benefit offered under the Component Plans (except a Component Plan which provides for the reimbursement of expenses) increases or decreases during the Plan Year, the Administrator may, on a reasonable and consistent basis, automatically increase or decrease a Participant's election by a corresponding amount of Salary Reduction to ensure that the Participant continues to receive the elected coverage under the Component Plans; provided, however, that if the increase or decrease is a significant change in cost, that the Participant shall be given the option to not elect to change his or her benefits.

5.6 Administrator's Adjustment of Salary Reduction. The Administrator maintains the right to adjust any Salary Reduction election made under the Plan to ensure that the Plan complies with the nondiscrimination provisions of Article X.

5.7 Failure to Make Initial Election. If an Employee who is first eligible to participate in the Plan fails to return the election form prior to the end of the Open Enrollment Period, the Employee shall be deemed to have elected not to participate in the Plan.

5.8 Elections for Subsequent Plan Years.

(a) Open Enrollment Period. An Open Enrollment Period shall occur prior to the beginning of each Plan Year. During the Open Enrollment Period, a Participant who wishes to change his existing election, shall have the opportunity to elect new or different coverage under the Plan effective for the subsequent Plan Year subject to the terms and conditions of the Component Plans.

(b) Failure to Reelect. If a Participant fails to reelect coverage but remains eligible to participate, the Participant shall be deemed to have elected the Benefits selected on the election for the preceding Plan Year and a Salary Reduction amount necessary to provide the same coverage. However, elections to contribute to the Medical Reimbursement Plan or Dependent Care Plan must be affirmatively elected each year by the Participant and a failure to reelect shall result in nonparticipation under the Medical Reimbursement Plan or Dependent Care Plan.

5.9 Continuation Coverage. During an Open Enrollment Period, any Participant, or a Qualified Beneficiary thereof, that has elected continuation of health coverage under the Plan, shall have the opportunity to elect new or different coverage under the Plan effective for the subsequent Plan Year. However, any such election shall be limited to health care options under the Plan.

5.10 Special Enrollment Period. In accordance with the Code Section 9801(f) and the regulations issued by the Department of Health and Human Services, an eligible Employee or Dependent who either incurs a loss of health coverage or becomes otherwise eligible for health coverage under this Plan shall be permitted to enroll for health coverage under the Plan in accordance with one of the special enrollment periods described in paragraphs (a) and (b) below.

(a) Loss of Health Coverage. An Employee who is otherwise eligible to enroll in the Plan but has not elected to participate in the Plan, or a Dependent of Employee that is not enrolled but otherwise eligible under the Plan, shall be permitted to enroll for coverage under the Plan provided:

(1) The Employee or Dependent was covered under another group health plan or had alternate health insurance coverage ("Prior Health Coverage") at the time coverage under this Plan was previously offered to the Employee.

(2) The Employee stated in writing at such time that Prior Health Coverage was the reason for declining enrollment.

(3) The Employee's or Dependent's Prior Health Coverage was either:

(i) under a continuation coverage provision and the coverage period was exhausted; or

(ii) was terminated as a result of loss of eligibility (including a result from a change in family status) or employer contributions toward such coverage were terminated.

Under the terms of the Plan, the employee requests such enrollment not later than 30 days after the date of a special enrollment event or the date a certificate of group health coverage is provided following a termination of health coverage.

(b) Dependent Special Enrollment Period. Any Employee, regardless of whether said Employee is currently enrolled for health coverage under the Plan, who experiences an increase in the number of Dependents whether through marriage, birth, adoption or placement for adoption, shall be permitted to enroll for health coverage under the Plan. During the "dependent special enrollment period," Employee shall have the opportunity to enroll all other Dependents who are otherwise eligible for coverage, including the Employee if not enrolled, provided the Employee elects enrollment within thirty (30) days commencing on the later of: (i) the date dependent coverage is made available; or (ii) the date of the marriage, birth, adoption, placement for adoption, or other event which results in the change of Dependents of Employee.

(c) Medical Spending Account. Notwithstanding the foregoing, the special enrollment rights conveyed under this Section shall not extend to include an election to contribute to the Medical Reimbursement Plan offered under the Plan.

5.11 Revocability of Elections. The Administrator shall permit a Participant to make a new election outside of the Open Enrollment Period for the remainder of a Plan Year only if the new election is for one of the following reasons:

(a) both the revocation and new election are made on account of and are consistent with a change in the Participant's family status, as set forth in Section 5.12;

(b) there is a significant change in the cost or coverage of the benefits previously elected by the Participant, as set forth in Section 5.13;

(c) both the revocation and new election are made on account of and pursuant to the terms of a "qualified medical child support order" as defined in ERISA Section 609, as set forth in Section 5.15; or

(d) the Participant, spouse or dependent becomes eligible for continuation coverage under Article IX and the Participant desires to elect to increase the amount of his or her Salary Reduction in order to pay for the continuation coverage.

5.12 Change in Family Status. A Participant may make a change in coverage during a Plan Year due to a change in family status, as set forth in this Section. A Participant must notify the Administrator and must complete a new election form to change coverage. The Participant's election shall only be deemed valid if the requested change in coverage is necessitated by and corresponds with the change in family status and is consistent with the terms and conditions of the affected Component Plan. This election shall be effective as of the first day of the month following the date the Participant provides the Administrator with a new election form reflecting the change in coverage due to a change in family status.

A change in family status shall include the following:

(a) a change in the Participant's marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(b) a change in the number of dependents of a Participant (as defined in Code Section 152), including a birth of a child, adoption, placement for adoption, or death of a dependent;

(c) any change in the employment status of the Participant, spouse or dependent which results in that individual becoming or ceasing to be eligible under this Plan or other employee benefit plan maintained by the employer of the Participant, spouse or dependent, including a termination or commencement of employment; a strike or lockout; a commencement or return from an unpaid leave of absence (including leave taken under FMLA); a change in work site; or a reduction or increase in hours of employment (including a switch between part-time and full-time);

(d) a dependent satisfies or ceases to satisfy the eligibility requirements for coverage due to attainment of age, student status, or any similar circumstances as provided under the Component Plan under which the employee receives coverage;

(e) a change in the place of residence of the Participant, spouse, or dependent; and

(f) a Participant, spouse, or dependent becoming or ceasing to be entitled to coverage under MediCare or Medicaid.

To the extent the Code, and regulations issued thereunder, alters this definition of change in family status, this Section 5.12 is intended to be interpreted in accordance with any revised definition or interpretation.

5.13 Significant Change in Cost of Benefit. If the cost of a Benefit option (other than a Component Plan which provides for the reimbursement of expenses) significantly increases during a coverage period, all affected Participants may make a corresponding change in their benefit election under the Plan. Changes that may be made include the following:

(1) In the case of a Benefit option which has experienced a significant decrease in cost, a Participant may make a prospective change to an election to commence participation in that Benefit option.

(2) In the case of a Benefit option what has experienced a significant increase in cost, a Participant may change an election to terminate such coverage and either, elect prospective coverage under another Benefit option providing similar coverage or drop coverage if no other Benefit option providing similar coverage is available.

For purposes of this Section, a "cost of increase or decrease" refers to an increase or decrease in the amount of the Salary Reductions contributed by a Participant under the Plan, whether than increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time status) or from an action taken by the Employer (such as reducing the amount of Employer contributions for a class of Employees).

In the case of an election for a Benefit option under the Plan which provides for the reimbursement of qualified dependent care expenses, a Participant's prior election may be changed only if the cost change is imposed by a dependent care provider who is not a relative of the employee.

5.14 Significant Change in Coverage of Component Plan Benefit.

(a) Significant Curtailment Without Loss of Coverage. If a Participant or a Participant's spouse or dependent experiences a "significant curtailment of coverage" under a Benefit option that is not a loss of coverage, including a significant increase in the deductible, co-payment, or the out-of-pocket cost sharing limit under a group health plan; the Participant may revoke his or her election for such coverage and prospectively elect to receive coverage under another Benefit option providing similar coverage. For this purpose, coverage under a Component Plan is "significantly curtailed" only if there is an overall reduction in coverage provided under the Component Plan so as to constitute reduced coverage generally. In this regard, the loss of one particular physician in a health

care provider network in most cases will not qualify for a significant curtailment of coverage under this Section.

(b) Significant Curtailment With Loss of Coverage. If a Participant or a Participant's spouse or dependent experiences a significant curtailment of coverage that is a "loss of coverage" under a Benefit option, the Participant may revoke his or her election for such coverage and elect either to receive coverage under another Benefit option providing similar coverage or to drop coverage if no other Benefit option providing similar coverage is available under the Plan. For this purpose, a "loss of coverage" means a complete loss of coverage under a benefit package option or other coverage option, including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation under a group health plan. In this regard, each of the following is considered to be a "loss of coverage" under this Section:

(1) a substantial decrease in the medical care providers available under the Benefit option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO;

(2) a reduction in the benefits for a specific type of medical condition or treatment with respect to which a Participant or the Participant's spouse or dependent is currently in a course of treatment; or

(3) any other similar fundamental loss of coverage;

(c) Addition or Improvement of Benefit Option. If during the Plan Year, a Component Plan adds a new benefit package option or other coverage option, or if coverage under an existing option is significantly improved, any Participant or Employee, who is otherwise eligible to participate in the Plan, may revoke his or her election under the Plan for the Plan Year and make an election on prospective basis for coverage under the new or improved benefit option.

(d) Change In Coverage Under Another Employer Plan. A Participant, or an Employee who is otherwise eligible to participate in the Plan but has elected not to participate, may make a prospective election change that is on account of and consistent with a change made under another employer plan (including a plan of the Employer or another employer) by the Employee or the Employee's spouse or dependent, provided the other employer plan allows participants to make an election change that would be permitted under the rules of IRS Reg. §1.125-4(c) and as provided in this Plan.

5.15 Qualified Medical Child Support Order. A Participant may make a change in coverage during a Plan Year to provide health coverage under the Plan for Participant's child or legal dependent pursuant to the terms of a judgment, decree, or order resulting from a family law proceeding, including a "qualified child support order" as defined under ERISA Section 609, requiring Participant to provide health coverage for the child. The Participant may also make a

change which cancels health coverage for the Participant's child or dependent provided the order requires the spouse, former spouse, or other individual to provide health coverage for the child.

5.16 Use of Electronic Medium for Participant Notices and Elections.

(a) Definition of Electronic Medium. "Electronic Medium" means an electronic method of communication between the Plan Administrator (or its designated representative) and Employee thereby allowing each party to send and receive notice and elections through the same medium. The only form of electronic communication permitted by the Plan shall be via electronic mail on the Employer's network or intranet, through an interactive website, or to a private e-mail address supplied to the Employer by the Employee for communication purposes. The electronic medium must be designed so that the information provided is no less understandable to the receiving party than a written paper document. The electronic medium shall be designed to alert the Employee, at the time a notice is provided, to the significance of the information in the notice (including identification of the subject matter of the notice), and provide any instructions needed to access the notice, in a manner than is readily understandable. The electronic medium shall be designed to preclude any person, other than the appropriate individual, from making a Participant election, such as Salary Reduction Agreement, or accessing individual participant account information.

(b) Disclosure and Consent Requirements.

(1) Disclosure Statement. Prior to electronically transmitting any consent or notice to the Employee, the Plan Administrator shall provide a statement which contains the following: (i) informs the Employee of the right to receive a paper document of the notice or other Plan-related material either prior to or after giving consent to electronic transmission; (ii) informs the Employee of the right to withdraw his or her consent at any time and the procedures for withdrawal, including any conditions or consequences arising from such withdrawal; (iii) describes the scope and duration of the consent as it related to various plan transactions; (iv) describes the procedures for updating Employee contact information; and (v) describes the hardware or software requirements needed to access and retain the notice.

(2) Consent. The Plan Administrator shall be exempt from the consent requirements of Section 101(c) of the Electronic Signatures in Global and National Commerce Act (E-SIGN) provided the Electronic Medium used to provide notices and Plan-related material is a medium that the Employee has the effective ability to access and the Employee is advised, each time a notice is transmitted, that he or she can request to receive the notice in paper form at no charge. The form of Electronic Medium utilized by this Plan shall be through an interactive website requiring the Employee to register an e-mail address for communication purposes.

(3) Changes in Hardware or Software Requirements. In the event of any changes in the hardware or software

requirements needed to access the Electronic Medium, the Plan Administrator, or its designated representative, shall provide a statement to each Employee of the revised requirements and the right to withdraw consent to receive electronic delivery of Plan-related materials without consequence.

(c) Participant Elections. The Plan Administrator, or its designated representative, shall be permitted to electronically distribute participant elections by Electronic Medium. Each Employee who is provided with enrollment or election information via Electronic Medium will also be informed by the Plan Administrator that he or she may receive a paper copy of the relevant documents upon request. A participant election will not be treated as being made available to an individual if such individual cannot effectively access the Electronic Medium for purposes of making the election. An election completed by an Employee via Electronic Medium shall be deemed as being provided in written form so long as the following requirements are satisfied:

(i) The Employee has a reasonable opportunity review, confirm, modify or rescind the terms of the election before the election becomes effective

(ii) The Employee receives, within a reasonable time, a confirmation of the election either through written paper form or by electronic mail (e-mail).

(d) Timing and Content of Elections and Notices. The provisions of this Section 4.10 shall in no way affect or alter the timing or content requirements applicable to each individual notice or document.

ARTICLE VI
FUNDING AND AVAILABLE BENEFITS

6.1 Funding. The Benefits provided herein shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of compensation as a Participant elects to forego pursuant to his or her Salary Reduction election. Amounts contributed through Salary Reduction shall be used to purchase the Benefits offered under this Plan.

6.2 Payment of Contributions While on FMLA Leave. Upon a Participant taking an unpaid FMLA leave of absence ("FMLA Leave"), each health care benefit elected by the Participant shall continue during the FMLA Leave for a period not longer than twelve (12) weeks, unless otherwise revoked by the Participant. During the unpaid FMLA Leave, the Participant shall be responsible for making the required contributions for such benefits during the period of the FMLA Leave. The Participant may select among the Prepayment Option, Catch-Up Option, and Pay-As-You-Go Option to pay the contributions during FMLA Leave.

(a) Prepayment. The Participant may elect to prepay the contributions prior to commencing the FMLA Leave. The prepaid contributions may be made from

salary, vacation pay or sick pay, to the extent permitted by applicable law and in a manner which will not defer compensation to a subsequent Plan Year. In the event, a Participant's FMLA Leave will span two Plan Years, the Participant may only prepay contributions for the remainder of the Plan Year and shall be required to utilize another payment option hereunder to make the contributions for the subsequent Plan Year. The Prepayment Option may not be required as a condition to remaining in the Plan, and prepayment may not be the sole method of making contributions hereunder.

(b) Pay-As-You-Go. The Participant may elect to pay the contributions on an after-tax basis as due. Payments shall be made on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as payments required for continuation coverage under Article VIII hereunder are made, under the Employer's existing rules for payment by employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant that is not consistent with FMLA.

Contributions under the Pay-As-You-Go Option may also be paid on a pre-tax basis from taxable compensation such as vacation pay or sick pay provided such payment will not defer compensation to a subsequent Plan Year.

(c) Catch-Up Option. The Employer may assume responsibility for advancing the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The contributions may be made on a pre-tax salary reduction basis from salary, vacation pay or sick pay when the Participant returns from FMLA Leave. The "Catch-Up Option" shall be applied in a manner consistent with Prop. Treasury Regulations Section 1.125-3.

The Prepayment Option and Catch-Up Option may not be offered without also offering the Pay-As-You-Go Option.

6.3 Uniformed Service Under USERRA. In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Participant who is absent from employment with the Employer on account of being in the Uniformed Services as defined in Section 3.23, may elect to continue participation in the Plan. The coverage period shall extend for the lesser of eighteen (18) months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions to pay for benefits elected during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to the payment of contributions with respect to FMLA Leave.

6.4 Provision of Benefits. The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount allocated under the Participant's election. The Benefits shall be provided pursuant to the terms and conditions of the Component Plans, where applicable, as shall be set forth from time to time in the individual Component Plan documents; provided, however, that the terms and conditions of the Component Plans are not inconsistent with the terms and conditions of this Plan. No Benefit

under the Plan shall be paid in any manner that defers the receipt of compensation beyond the last day of the Plan Year.

6.5 Spending Accounts. The amounts designated by Participant in his Salary Reduction Agreement to be applied for medical reimbursement or dependent care assistance shall be credited to a separate ledger account in the Participant's name. Such amounts credited to a Participant's spending account for any Plan Year shall be used only toward the payment of or reimbursement for Participant's Eligible Expenses incurred for such Plan Year, as determined under Article VII and Article VIII.

6.6 Reimbursements. Except as otherwise provided in this Plan or any Component Plan, contract or arrangement established to provide Benefits, reimbursement of Expenses shall be made at such time and in such amounts as shall be determined by the Employer in accordance with Treasury Regulations Section 1.125-2 Q&A 7(b)(2). The amount credited to a Participant's spending account(s) under any Component Plan for any Plan Year shall be used only to reimburse the Participant for expenses incurred for such Plan Year, and only if the Participant applies for reimbursement during the reimbursement time limits (including any extended grace period) set forth by the Component Plan.

6.7 Taxable Benefits. If offered by the Employer, Employees shall be permitted to elect to receive certain permitted taxable benefits. An employee receiving such benefits shall be treated as having received, at the time that the benefit is received, cash compensation equal to the full value of the benefits and then as having purchased the benefits with after-tax employee contributions.

The Employer shall also be permitted to allow Participants to elect health coverage under the Plan for an individual who is not the spouse or Dependent of the Participant; provided, however, that the fair market value of such health coverage is included in the Participant's W-2 income.

ARTICLE VII
DEPENDENT CARE SPENDING ACCOUNTS

7.1 Component Plan. This Article VII shall set forth the provisions for the RIVERSIDE COUNTY TRANSPORTATION COMMISSION DEPENDENT CARE REIMBURSEMENT PLAN ("Dependent Care Plan"). Benefits under the Dependent Care Plan shall take the form of reimbursement by the Employer for Eligible Dependent Care Expenses incurred by a Participant during the Plan Year. A Participant shall only be entitled to reimbursement of Eligible Dependent Care Expenses incurred after electing to participate in the Dependent Care Plan.

7.2 Annual Election. For each Plan Year, a Participant shall affirmatively specify the amount of the Participant's Salary Reduction to be allocated to the Dependent Care Plan. The maximum annual amount which may be allocated by a Participant may not exceed the least of the following:

(a) $5,000 (or $2,500 in the case of a married Participant filing a federal income tax return separate from this Spouse);

(b) If the Participant is unmarried at the close of the Plan Year, his Compensation for such Plan Year; or

(c) If the Participant is married at the close of a Plan Year, his Compensation for such Plan Year.

Notwithstanding the above, the maximum election amount must also be reduced by the amount of any tax-exempt dependent care assistance benefits received by the Participant or his Spouse from any other employer during the Plan Year.

For purposes of this Section 7.2, "Compensation" means all earnings of a Participant reportable on Form W-2 for the Plan Year, but does not include any amounts received from a dependent care assistance plan, any pension or annuity, or as unemployment or worker's compensation in accordance with Section 129(e)(2) of the Code.

For purposes of calculating the maximum annual benefit for a Plan Year, Compensation shall be the lesser of the Participant's Compensation determined under the preceding paragraph or the Participant's Spouse's Compensation, if the Participant is married at the close of the Plan Year. If during any taxable month the Participant's Spouse is a Student or is physically or mentally incapacitated, the Spouse's Compensation for such month shall be deemed to be $200 if there is one Qualifying Individual for whom the Participant incurs Eligible Dependent Care Expenses during the Plan Year, or $400 if there are two or more Qualifying Individuals, in accordance with Section 21(d) of the Code.

7.3 Spending Account. The sole source for payment of Dependent Care Benefits under this Article VII shall be the unfunded accounts established for each Participant pursuant to his annual election under Section 5.4. The Plan Administrator shall reimburse each Participant for his Eligible Dependent Care Expenses and his spending account shall be debited accordingly. The aggregate reimbursements made at any time during the Plan Year shall not exceed the Participant's total contributions to the Dependent Care Plan for the Plan Year.

7.4 Reimbursement of Eligible Expenses. A Participant shall only be entitled to reimbursement of substantiated Eligible Dependent Care Expenses incurred during the Plan Year. An Eligible Dependent Care Expense shall be considered incurred when the services giving rise to such expense are provided, irrespective of when Participant is formally billed or pays for such expenses. The amount of reimbursement received by a Participant shall at no time exceed the balance of his dependent care spending account. An expense in excess of the account balance shall not be reimbursed. An expense must be incurred during the Plan Year to be eligible for reimbursement; however, such reimbursement may be made after the Participant's cessation of participation or after the Plan Year as provided in Section 7.7. If a Participant ceases participation in the Plan prior to the end of the Plan Year, whether due to termination of employment or otherwise, and has unreimbursed contributions remaining in his or her dependent care spending account such Participant may receive reimbursement for claims for post-

termination Eligible Dependent Care Expenses incurred during the remaining Plan Year or the Grace Period in Section 7.7, immediately following that Plan Year.

7.5 Limitations on Reimbursement/Forfeiture. The Employer's payment of Dependent Care Benefits for any Plan Year will be limited to the lesser of (1) the Participant's Eligible Dependent Care Expenses for the year, or (2) the amount of the Participant's election for Dependent Care Benefits for the year. A Participant shall receive no reimbursement for Dependent Care Benefits which are elected but unused during a Plan Year, for any reason. Any balance remaining in the Participant's spending account after all Eligible Dependent Care Expenses have been paid shall be forfeited by the Participant and the account balance reduced to zero.

7.6 Claim for Benefits. Each Participant who desires to receive reimbursement under the Plan for Eligible Dependent Care Expenses shall submit to the Plan Administrator or the designated claims representative at the times indicated in Section 7.7, a form provided by the Employer, or responses to other supplementary factual requests, containing the following information:

(a) the name, age, and relationship to the Participant of the Qualifying Individual for whom the Eligible Dependent Care Expenses were incurred;

(b) if any of the Qualifying Dependent Care Services were performed outside the Participant's home for a Qualifying Individual incapable of caring for himself, a statement as to whether said Qualifying Individual regularly spends at least eight (8) hours a day in the Participant's home;

(c) if any of the Qualifying Dependent Care Services are performed for a Qualifying Individual who is physically or mentally incapable of caring for himself, a statement to that effect;

(d) the nature and dates of performance of the Qualifying Dependent Care Services subject to reimbursements;

(e) the relationship, if any, to the Participant of the person(s) providing the Qualifying Dependent Care Services;

(f) a statement indicating that the Participant will include on his federal income tax return the name, address, and (except in the case of a tax-exempt Qualifying Day Care Center) the taxpayer identification number of the provider of the Qualifying Dependent Care Services;

(g) if the Participant is married and his Spouse is employed, a statement of the Spouse's Compensation; or if the Spouse is not employed, a statement that the Spouse is incapacitated or the Spouse is a student, indicating the months of the year during which the Spouse attends an Educational Institution on a full-time basis;

(h) a statement as to the amount, if any, of tax-exempt dependent care assistance benefits received from any other employer by the Participant or his Spouse during the Plan Year; and

(i) evidence of indebtedness or payment by the Participant to the third party who performed the Qualifying Services.

As soon as administratively feasible following the end of each month, the Plan Administrator shall review all the forms submitted by Participants during that month in accordance with the foregoing procedures and shall pay each Participant the Dependent Care Benefits which each Participant is entitled to receive, in accordance with this Article VII. No amounts shall be reimbursed by the Plan Administrator until after the expense has been properly substantiated in accordance with Section 7.6.

7.7 Time Limit; Grace Period. No expenses shall be reimbursed for any Plan Year unless the Participant applies for such reimbursement within three (3) months after the end of such Plan Year. However, any Participant who has unreimbursed contributions remaining in his or her spending account at the end of a Plan Year may submit claims for Eligible Dependent Care Expenses incurred during the period that begins immediately following the close of the Plan Year and ends on the day that is two months plus fifteen (15) days following close of that Plan Year ("Grace Period") under the following conditions:

(a) Applicability. In order for a Participant to be reimbursed for Eligible Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her dependent care spending account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Dependent Care Reimbursement Plan coverage that is in effect on the last day of that Plan Year; or (2) an Employee subject to Section 7.4.

(b) No Cash-Out or Conversion. Prior Plan Year Dependent Care Reimbursement Plan amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, prior Plan Year Dependent Care Reimbursement Plan amounts may not be used to reimburse Eligible Medical Care Expenses.

(c) Reimbursement of Grace Period Expenses. Eligible Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Dependent Care Reimbursement Plan will be reimbursed and charged first against any available Prior Plan Year Dependent Care Reimbursement Plan amounts and then against any amounts that are available to reimburse expenses that are incurred during the current Plan Year. All claims for reimbursement under the Dependent Care Reimbursement Plan will be paid in the order in which they are approved.

(d) Run-Out Period and Forfeitures. Claims for expenses incurred during the Grace Period must be submitted for reimbursement within three (3) months after the end of the Grace Period. Any prior Plan Year Dependent Care

Reimbursement Plan amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends. The Participant will forfeit all rights with respect to such balance.

7.8 No Reversion to Employer. At no time shall any part of Plan assets be used for, diverted to, purposes other than for the exclusive benefit of Participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

ARTICLE VIII
MEDICAL SPENDING ACCOUNTS

8.1 Component Plan. This Article VIII shall set forth the provisions for the RIVERSIDE COUNTY TRANSPORTATION COMMISSION MEDICAL REIMBURSEMENT PLAN ("Medical Reimbursement Plan"). Benefits under the Medical Reimbursement Plan shall take the form of reimbursement by the Employer for Eligible Medical Care Expenses incurred by a Participant during the Plan Year. A Participant shall only be entitled to reimbursement of Eligible Medical Care Expenses incurred after electing to participate in the Medical Reimbursement Plan.

8.2 Annual Election. For each Plan Year, a Participant shall affirmatively specify the amount of the Participant's Salary Reduction to be allocated to the Medical Reimbursement Plan. The maximum annual Medical Reimbursement Benefit elected by a Participant may not exceed Two Thousand Five Hundred Dollars ($2,500.00).

8.3 Spending Account. The sole source for payment of Medical Reimbursement Benefits under this Article VIII shall be the unfunded accounts established for each Participant pursuant to his annual election under Section 5.3. The Plan Administrator shall reimburse each Participant for his Eligible Medical Care Expenses and his spending account shall be debited accordingly. The aggregate reimbursements made at any time during the Plan Year shall not exceed the Participant's total contributions to the Medical Reimbursement Plan for the Plan Year. A Participant's Medical Reimbursement Benefits shall be uniformly available throughout the Plan Year.

8.4 Reimbursement of Eligible Expenses. A Participant shall be entitled to reimbursement of Eligible Medical Care Expenses in an amount that does not exceed his total contribution to the Medical Reimbursement Plan for the Plan Year. Each payment hereunder shall be a charge to the Participant's medical care spending account. Reimbursement shall be provided to any individual only for Eligible Medical Care Expenses incurred while that individual is a Participant; however, such reimbursement may be made after such participation ceases. An Eligible Medical Care Expense shall be considered incurred when the services giving rise to such expense are provided, irrespective of when such expenses are billed to the Participant. Reimbursement shall not be made for any amount that does not qualify as an Eligible Medical Care Expense or exceeds the annual contribution.

8.5 Limitations on Reimbursement/Forfeiture. The Employer's payment of Benefits from the Medical Reimbursement Plan for any Plan Year will be limited to the lesser of

(1) the Participant's Eligible Medical Care Expenses for the Plan Year (including the grace period described in Section 8.7), or (2) the amount of the Participant's annual election to the Medical Reimbursement Plan. A Participant shall receive no reimbursement for amounts which are elected but unused during a Plan Year, for any reason. Any balance remaining in the Participant's medical care spending account after all Eligible Medical Care Expenses have been paid shall be forfeited by the Participant and the account balance reduced to zero.

8.6 Claims for Benefits. To receive reimbursement for Eligible Medical Care Expenses, a Participant must submit a written claim for benefits to the Plan Administrator or the designated claims representative at the times indicated in Section 8.7. Said claim shall include the following:

(a) the name of the person or persons on whose behalf Eligible Medical Care Expenses have been incurred;

(b) a description of the nature and dates of service or expense so incurred;

(c) a statement indicating that such expense or expenses have not otherwise been paid through insurance or reimbursed from any other source; and

(d) a receipt or other evidence of indebtedness or payment by the Participant of the service or expense.

The Plan Administrator will review the claim as soon as administratively feasible following the end of each month, and will advise the Participant of any reimbursement amounts to which he is entitled. If a Participant believes he has been incorrectly denied reimbursement or has not been advised of his Benefits under the Medical Reimbursement Plan, he may submit a written request to the Plan Administrator to provide either an explanation of how Eligible Medical Care Expenses are reimbursed or further information of his Benefits. The Plan Administrator must respond to such a request within a reasonable time. No amounts shall be reimbursed by the Plan Administrator until after the expense has been properly substantiated in accordance with Section 8.6.

Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for reimbursement, a written notice stating in a format determined to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) specific reference to pertinent plan provisions on which the denial is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim; and (4) an explanation of the claim review procedure set forth below.

Within 60 days of receipt by a claimant of a notice denying a claim under this Section, the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator or by the Administrator which may be appointed by the Employer for that purpose. The Plan Administrator may extend the 60-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Plan

Administrator or Administrator shall make a decision promptly, and not later than 60 days after the Plan Administrator's receipt of a request for review, unless special circumstances (such as the notice to hold a hearing, if the Administrator deems one necessary) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review. The decision on review shall be in writing and shall include specific references for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

8.7 Time Limit; Grace Period. No expenses shall be reimbursed for any Plan Year unless the Participant applies for such reimbursement within three (3) months after the end of such Plan Year. However, any Participant who has unreimbursed contributions remaining in his or her spending account at the end of the Plan year may submit claims for Eligible Medical Care Expenses incurred during the period that begins immediately following the close of that Plan Year and ends on the day that is two months plus fifteen (15) days following close of that Plan Year ("Grace Period") under the following conditions:

(a) Applicability. In order for a Participant to be reimbursed for Eligible Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her medical spending account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Medical Reimbursement Plan coverage that is in effect on the last day of that Plan Year; or (2) a Qualified Beneficiary who has COBRA coverage under the Medical Reimbursement Plan on the last day of that Plan Year.

(b) No Cash-Out or Conversion. Prior Plan Year Medical Reimbursement Plan amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, prior Plan Year Medical Reimbursement Plan amounts may not be used to reimburse Eligible Dependent Care Expenses.

(c) Reimbursement of Grace Period Expenses. Eligible Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Medical Reimbursement Plan will be reimbursed and charged first against any available Prior Plan Year Medical Reimbursement Plan amounts and then against any amounts that are available to reimburse expenses that are incurred during the current Plan Year. All claims for reimbursement under the Medical Reimbursement Plan will be paid in the order in which they are approved.

(d) Run-Out Period and Forfeitures. Claims for expenses incurred during the Grace Period must be submitted for reimbursement within three (3) months after the end of the Grace Period. Any prior Plan Year Medical Reimbursement Plan amounts that remain after all reimbursements have been made for the Plan Year and

its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends. The Participant will forfeit all rights with respect to such balance.

8.8 No Reversion to Employer. At no time shall any part of Plan assets be used for, diverted to, purposes other than for the exclusive benefit of Participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

ARTICLE IX
CONTINUATION COVERAGE

9.1 In General. The following provisions shall apply to Benefits provided to eligible Employees and to their eligible dependents under the Plan, but only to the extent that the Benefits selected pertain to health care coverage providing medical, surgical, or hospital benefits and to plans providing ancillary medical coverage such as dental, vision, or prescription drug benefits. This coverage shall be continued pursuant to the federal continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as codified under Code Section 4980B, and the regulations promulgated thereunder.

9.2 Definitions. For purposes of this Article IX, the following words and phrases are intended to supplement, and in some instances replace, the defined terms listed generally in Article III and to the extent of any conflict between the terms set forth herein and those of Article III, the defined terms set forth herein shall control:

(a) "Dependent" means an individual who meets the definition of dependent under the participating Employer provided health plan covering the eligible Employee. For the purposes of any medical reimbursement plan, dependents will also include individuals who are dependents within the meaning of Section 152(a) of the Code.

No person shall be considered a dependent of more than one Employee.

If both an Employee and an Employee's spouse are employed by the Employer, dependent children may be covered by either spouse, but not by both.

(b) "Election period" means the sixty (60) day period during which a Qualified Beneficiary who would lose coverage as a result of a Qualifying Event may elect continuation coverage. This sixty (60) day period begins not later than the date of termination of coverage as a result of a Qualifying Event and ends not earlier than the sixty (60) days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

(c) "Full-time student" means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other

accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain full-time student status.

(d) "Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

(e) "Qualified Beneficiary" means an individual who, on the day before the Qualifying Event, is covered under this Plan as the covered Employee, the spouse of the covered Employee or dependent child of the covered Employee. Qualified Beneficiary shall include a child who is born to (or placed for adoption with) a covered Employee during the coverage period. The term Qualified Beneficiary does <u>not</u> include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and Section 861(a)(3)). The term Qualified Beneficiary also does <u>not</u> include a Covered Employee's domestic partner regardless of whether such person was a covered dependent under the Plan prior to the Qualifying Event. If an individual is not a Qualified Beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

(f) "Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a Qualified Beneficiary:

(1) the death of the covered Employee;

(2) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered Employee's employment;

(3) the divorce or legal separation of the covered Employee from such covered Employee's spouse;

(4) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);

(5) a dependent child who ceases to be a dependent child under the terms of this Plan;

(6) the Employer's filing for Chapter 11 reorganization as it would affect retiree coverage.

(g) "University/college" means an accredited institution listed in the current publication of accredited institutions of higher education.

9.3 <u>Continuation Coverage</u>. To the extent required by Section 9.1 above, a Qualified Beneficiary who would lose health coverage under this Plan as a result of a Qualifying

Event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a Qualified Beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage (i.e., single, family, etc.).

9.4 Type of Coverage.

(a) Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a Qualifying Event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

Continuation coverage available to a Qualified Beneficiary under this provision shall apply only to the type and level of health coverage under the Plan that a Qualified Beneficiary was actually receiving on the day before the Qualifying Event. The Qualified Beneficiary may not change his or her election except as otherwise provided under Sections 5.9 and 5.11(d).

(b) Medical Spending Account. Notwithstanding Section 9.4(a) above, an Employee that was participating in the Plan prior to the Qualifying Event may be eligible to elect continuation coverage under the medical spending account, subject to subsection (c).

(c) Unavailability of Continuation Coverage. Continuation coverage under a medical spending account shall not be offered if all of the following three conditions are satisfied:

(i) Employer provides other health coverage options which are available to the Employee;

(ii) The maximum amount required under the Plan for a year of continuation coverage under this Article IX equals or exceeds the maximum benefit available under the Plan for the year; and

(iii) The contribution premium for the remainder of the Plan Year in which the Qualifying Event occurred will exceed the maximum benefit still available to the Participant under the Plan as of the date of the Qualifying Event. The determination of whether this condition has been

satisfied will be made by the Plan Administrator on a case by case basis at the time of the Qualifying Event.

(d) Limited Continuation Coverage. In the event the Plan satisfies only the first two conditions set forth in subparagraph (i and ii) above, the Employer shall offer continuation coverage under the medical spending account for the remainder of the Plan Year for the year in which the Qualifying Event occurred.

(e) Full Continuation Coverage. If the Plan Administrator finds that the Plan does not satisfy the first two conditions set forth in subparagraph (i and ii) above, the Employer must offer continuation coverage under the Plan to the Employee for the duration of the coverage period required under Section 9.5.

9.5 Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event and ending not earlier than the earliest of the following:

(a) Initial 18-Month Coverage Period. If the Qualifying Event is a termination of employment (other than for gross misconduct) or a reduction in employment hours of a covered Employee, the coverage period for the Employee and his or her dependents shall extend for eighteen (18) months after the date of the Qualifying Event;

(b) Disability Extension. The initial eighteen (18) month coverage period described in (a) above may be extended to twenty-nine (29) months after the date of the Qualifying Event in the event the Qualified Beneficiary was disabled upon termination of employment or during the first sixty (60) days of continuation coverage. The Qualified Beneficiary must provide the Plan Administrator with notice of Social Security disability determination within sixty (60) days of the disability determination and prior to the expiration of the initial eighteen (18) month continuation period provided in (a) above to become eligible for this extension of continuation coverage.

(c) Extension of Coverage Period. The initial eighteen (18) month coverage period described in (a) above may be extended to thirty-six (36) months after the date of the Qualifying Event upon the occurrence of a second Qualifying Event prior to the expiration of the initial eighteen (18) month coverage period. The Qualified Beneficiary must notify the Plan Administrator of the second Qualifying Event within sixty (60) days of the date of the second Qualifying Event and prior to the expiration of the initial eighteen (18) month period. In no event shall continuation coverage extend for a period greater than thirty-six (36) months.

(d) 36-Month Coverage Period. In the case of any Qualifying Event causing the loss of coverage, except those Qualifying Events identified in (a) above, the coverage period for the Employee and his or her dependents shall extend for thirty-six (36) months after the date of the Qualifying Event.

9.6 Notification Requirements.

(a) Notification by Qualified Beneficiary. Each covered Employee or Qualified Beneficiary must notify the Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within sixty (60) days after the date of such occurrence. This sixty (60) day time limit shall only apply to those occurrences as described in this paragraph which occur after the date of the enactment of the Tax Reform Act of 1986.

(b) Notification by Employer. The Employer shall notify the Administrator within thirty (30) days of a Qualifying Event, as required by federal law.

(c) Notification to Qualified Beneficiary. The Administrator shall provide written notice to each covered Employee and spouse of such covered Employee of his or her right to continuation coverage under this provision upon commencement of coverage under a Component Plan providing health coverage, as required by federal law.

The Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision within fourteen (14) days of receiving notice of the occurrence of a Qualifying Event, as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, the Employer shall only be required to notify a Qualified Beneficiary of his or her right to elect continuation coverage if the covered Employee or the Qualified Beneficiary notifies the Employer of such Qualifying Event within sixty (60) days after the date of such Qualifying Event.

Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

9.7 Termination of Continuation Coverage. The continuation coverage provided hereunder shall be terminated prior to the expiration of the coverage periods provided in Section 9.5 above upon the earlier of the following:

(a) with respect to continuation coverage under a medical spending account, the last day of the Plan Year in which the Qualified Beneficiary experiences the Qualifying Event.

(b) the date on which the Employer ceases to provide any group health plan to any Employee;

(c) the date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision provided the deficiency is not an "insignificant amount" as described in Section 9.8;

(d) the date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent. However, if the other group health plan has a preexisting condition

limitation, continuation coverage under the Plan will not cease while such preexisting condition limitation under the group plan remains in effect (taking into account prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996); or

(e) the date on which the Qualified Beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare).

9.8 Contribution.

(a) A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable premium required by the Employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the requirements of applicable federal law. A Qualified Beneficiary may elect to pay such premium in installments as indicated by the Employer.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made within thirty (30) days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) or (b) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within forty-five (45) days of the date of the election.

A premium payment received by the Employer which is deficient by an insignificant amount shall be treated as full payment of the premium amount. For purposes of this section, an insignificant amount is an amount not greater than the lesser of (i) ten percent (10%) of the required amount; or (ii) fifty dollars ($50.00). Alternatively, in the event an Employer receives an insufficient payment premium, the Employer retains the option of taking steps to collect the deficient insignificant amount by notifying the Qualified Beneficiary of the deficiency and allowing thirty (30) days after date of the notice for payment of the deficiency.

9.9 Coordination with State Continuation Coverage. In the event a Qualified Beneficiary is entitled to less than 36 months of federal continuation coverage as a result of a Qualifying Event, the Qualified Beneficiary will be notified prior to the expiration of federal continuation coverage if he or she is eligible to elect an extension of continuation coverage under the Plan for an additional period of up to 36 months from the date of the Qualifying Event pursuant to the Section 1366.20 et. seq. of the California Health and Safety Code (the "California Continuation Benefits Replacement Act" or "Cal-COBRA Program").

A covered employee's dependent who, (1) on the day before the Qualifying Event, is covered under this Plan as the registered domestic partner of the covered Employee and (2) loses health coverage under this Plan as a result of a Qualifying Event shall be entitled to state continuation coverage subject to the eligibility, election and contribution requirements set forth under the Cal-COBRA Program.

ARTICLE X
DISCRIMINATION

10.1 Nondiscrimination Requirements.

(a) Nondiscriminatory Class. The Employer shall not provide benefits to a classification of Employees which the Secretary of the Treasury finds to be discriminatory under Section 125 of the Code and the Regulations issued thereunder.

(b) Key Employees. The Employer shall not provide qualified Benefits to Key Employees in amounts that exceed twenty-five (25%) of the aggregate of such benefits provided for all eligible Employees under the Plan. For purposes of this subsection, qualified Benefits shall not include benefits which are includible in gross income.

10.2 Avoid Discrimination.

(a) Ability to Reject Election. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of Employees in whose favor discrimination may not occur in violation of Section 125 of the Code or the Regulations issued thereunder, it may, but shall not be required to, reject any election or reduce contributions or non-taxable benefits to assure compliance with Section 125 of the Code. Any act taken by the Administrator pursuant to this Section shall be in a nondiscriminatory and uniform manner.

(b) Manner of Rejecting Election to Avoid Discrimination. In the event the Administrator determines that it is necessary to reject an election or reduce contributions or non-taxable benefits, the rejection shall be carried out as set forth in this subsection. Non-taxable benefits of the affected Key Employee or Highly Compensated Participant who has elected the highest amount of non-taxable benefits shall be reduced until the discrimination tests set forth in this subsection are satisfied or until the amount of his or her non-taxable benefit equals the non-taxable benefit of the affected Participant who has elected the second highest amount of non-taxable benefits. This process shall continue until the discrimination tests are satisfied. Any reduction made pursuant to this subsection shall be made proportionately among non-insured benefits and once all non-insured benefits are expended, proportionately among insured benefits. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this subsection shall be forfeited and deposited into the general account containing all Flexible Benefit Dollars.

10.3 Reimbursement Plans. The Plan is intended not to discriminate in favor of "highly compensated individuals" (as defined in Section 414(q) of the Code with respect to the Dependent Care Plan and as defined in Section 105(h) of the Code with respect to the Medical Reimbursement Plan) as to eligibility to participate, contributions, and/or Benefits under the Medical Reimbursement Plan and Dependent Care Plan (the "Reimbursement Plans"). If the Plan Administrator determines the operation of either Reimbursement Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from

coverage under the applicable Reimbursement Plan such Participants and/or reduce such contributions and/or Benefits to ensure compliance with the nondiscrimination requirements of Section 129 and 105 of the Code.

ARTICLE XI
ADMINISTRATION

11.1 Allocation of Responsibility for Administration.

(a) Designated Representatives. The Employer may appoint an individual or an administrative committee to serve at its discretion as Administrator. The Administrator shall have only those powers, duties, responsibilities and obligations as are specifically given to the Administrator under the Plan.

(b) Employer Responsibilities. The Employer shall have the sole responsibility for making the contributions provided for under Article VI and shall have the sole authority to amend or terminate, in whole or in part, the Plan at any time.

(c) Administrator's Responsibilities. The Administrator shall have the sole responsibility for the administration of the Plan, as set forth herein. The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. The Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee. Neither the Administrator, nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in the Plan.

11.2 Transfer of Duties. The Employer may, at any time, assign all or any portion of the Administrator's duties to a contracting third party.

11.3 Powers and Duties of Administrator.

(a) Powers and Duties Delegated to Administrator. The Administrator shall supervise the administration of the Plan. The Administrator shall be responsible for ensuring that the terms and conditions of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan without discrimination. The Administrator shall have full power to administer the Plan, subject to the applicable requirements of the law and any Administration Agreement executed by and between the Employer and the Administrator. For this purpose, the Administrator's powers shall include the following:

(1) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder;

(2) to prescribe the procedures for the Participants to follow in filing applications for benefits and to prepare forms to be used by the Participants;

(3) to prepare and distribute, in such manner as the Administrator determines appropriate, information explaining the Plan;

(4) to receive from the Employer, Participants, Participant's spouses and Dependents, and other persons such information as shall be necessary for the proper administration of the Plan;

(5) to furnish to the Employer and the Participants, upon request, annual reports detailing the administration of the Plan;

(6) to receive, review and keep on file records pertaining to the Plan, as the Administrator deems convenient and proper;

(7) to allocate its administrative responsibilities;

(8) to appoint or employ individuals and any other agents the Administrator deems advisable, including legal and actuarial counsel, to assist in the administration of the Plan;

(9) to adopt such rules as the Administrator deems necessary, desirable or appropriate, subject to applicable law. All rules and decisions of the Administrator shall be uniformly and consistently applied to all Participants in similar circumstances; and

(10) to take all other steps necessary to properly administer the Plan in accordance with its terms and conditions and the requirements of the applicable law.

11.4 Powers and Duties Not Delegated to Administrator. The Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan, except as may be expressly provided herein. Interpretations of the provisions of the Plan shall not be deemed to be additions, subtractions, or modifications of the Plan.

11.5 Nondiscriminatory Exercise of Authority. Whenever in the administration of the Plan any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

11.6 Incapacity of Participant. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit hereunder or an installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such Participant or to such person or to the person's legal representative or to a relative or friend of such person on such person's behalf, or the Administrator may apply the payment for the benefit of such Participant in such manner as the Administrator considers advisable. Any payment of a benefit

or installment in accordance with the provisions of this Section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

11.7 Indemnification of Administrator. The Employer agrees to indemnify any Employee serving as Administrator (including any Employee or former Employee who formerly served as Administrator), against any and all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is made in good faith pursuant to the provisions of the Plan and not as a result of the Administrator's gross negligence or willful misconduct.

ARTICLE XII
CLAIMS PROCEDURE

Except as provided under Article VII with respect to payment of dependent care assistance benefits and under Article VIII with respect to payment of eligible medical expenses, all claims for benefits that are provided through insurance contracts, whether such contracts are between the insurer and the Employer or the insurer and the Participant, shall be made by filing a claim for benefits in accordance with the claims procedure set forth under the insurance contract. The Employer does not have the authority or responsibility for processing, reviewing or paying such claims. All disputes regarding those claims shall be resolved in accordance with the procedure set forth in the separate Component Plan document concerning those benefits.

ARTICLE XIII
AMENDMENTS, TERMINATION AND ACTION BY EMPLOYER

13.1 Action by Employer. Any action by the Employer under this Plan, including but not limited to, termination of this Plan, shall be by action of the Employer, or by any person or persons duly authorized by action of the Employer to act on its behalf.

13.2 Amendments. The Employer reserves the right to make, from time to time, any amendment or amendments to this Plan as it deems necessary or desirable, without retroactive effect, unless specifically permitted to comply with the law.

13.3 Right to Terminate. The Employer may terminate this Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the Employer's procedures.

13.4 Plan Termination. Upon the termination of the Plan, the Administrator may determine the best method to make payments to the effected Participants.

ARTICLE XIV
HIPAA PRIVACY STANDARDS

14.1 Protection of Individually Identifiable Health Information. The Employer and the Plan have adopted policies and procedures ("Privacy Policy") for the sole and limited purpose of complying with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 164.102 *et seq.*, as amended (the "Privacy Rule"). The manner in which these provisions will be administered shall in no way affect, or be taken into account in determining, the benefits under the Plan with respect to any individual.

14.2 Definitions. The defined terms and phrases used in this Article shall carry the same meaning and intent set forth under the Privacy Rule, and in some instances may replace the defined terms listed generally in Article III and to the extent of any conflict between the terms set forth herein and those of Article III, the defined terms shall carry the meaning prescribed under the Privacy Rule.

14.3 Identity of Plan Sponsor. The Employer shall be the Plan Sponsor for purposes of the Privacy Rule when performing Plan Administration functions or Plan Sponsor functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rule, and when acting on behalf of the Plan's participants and beneficiaries with respect to Participation and Enrollment Information. The Privacy Official shall act for the Plan Sponsor and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

14.4 Responsibilities and Undertakings. The Plan Sponsor shall be responsible for making any necessary certifications to the Plan. Such certifications shall be delivered to the Plan's Privacy Official. The Plan Sponsor also undertakes and agrees that it:

(a) Shall not use or disclose Protected Health Information ("PHI") except as to those uses specifically permitted under the Privacy Rule.

(b) Shall require any agents or subcontractors to whom it discloses PHI to agree to the same restrictions on the use and disclosure of PHI as apply to the Plan Sponsor;

(c) Shall not use or disclose PHI for any employment-related actions of Employer;

(d) Shall not use or disclose PHI in connection with any other benefits or benefit plan, program, or arrangement of Employer.

(e) Shall report to the Privacy Official any uses or disclosures of PHI inconsistent with the Plan's Privacy Policy of which it becomes aware.

(f) Shall make PHI available in accordance with an individual's right of access in accordance with the Plan's Privacy Policy.

(g) Shall make PHI available for amendment and shall incorporate amendments in accordance with the Plan's Privacy Policy.

(h) Shall make information available to provide any required accounting of disclosures of PHI in accordance with the Plan's Privacy Policy.

(i) Shall make available to the Secretary of Health and Human Services its internal practices, books, and records relating to the use and disclosure of PHI from the Plan for purposes of determining the Plan's compliance with the Privacy Rule.

(j) Shall, if feasible, return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible.

(k) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established.

14.5 Uses and Disclosures of Protected Health Information.

(a) Certification. The Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, may disclose PHI to the Plan Sponsor only following receipt of the Plan Sponsor's certification that the Plan has been amended in accordance with the requirements of the Privacy Rule.

(b) Plan Administration. The Plan Sponsor shall be permitted to the limited use and disclosure of PHI for purposes of plan administration, including all Payment Activities and Health Care Operations, as permitted under the Plan’s Privacy Policy.

(c) Compliance with Privacy Rule. The Plan Sponsor shall be entitled to those uses and disclosures of PHI as permitted by the Privacy Rule to the extent necessary for compliance, including but not limited to any uses and disclosures permitted (1) without permission from an individual; (2) only with explicit or implicit authorization; or (3) because the PHI has been cleansed.

(d) Participation and Enrollment Information. Participation and Enrollment Information may be disclosed as necessary to the Plan Sponsor.

(e) Summary Health Information. Summary Health Information may be disclosed to the Plan Sponsor for the limited purpose of performing Plan Sponsor functions.

(f) Individuals With Access to PHI. The Privacy Official and his or her delegates, if any, are permitted to have access to PHI disclosed to or by the Plan. In

addition, the Plan Sponsor shall designate the individual(s) or group(s) of individuals under the direct control of the Plan Sponsor who are permitted to have access to PHI disclosed by or to the Plan.

(g) Limitations on Disclosures of, Access to, and Uses of PHI. PHI may be disclosed from the Plan only for Plan Administration Functions performed on behalf of the Plan, and the other purposes identified in the Plan's Privacy Policy.

14.6 Hybrid Entity. The provisions of this Section shall apply only to the health care component of the Plan.

ARTICLE XV
GENERAL PROVISIONS

15.1 Written Plan. The Administrator shall, upon request, provide each Participant with a copy of the written Plan(s) detailing the benefits available to the Participant.

15.2 No Trust Fund Required. The Employer shall have no obligation, but shall have the right, to insure any benefits under the Plan or to establish any fund or trust for the payment of benefits under the Plan.

15.3 Insured Benefits. The Employer shall have no responsibility for the payment of any benefits covered under the Component Plans provided by policies of insurance.

15.4 Rights to Employer's Assets. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer and the Administrator shall not be liable therefore in any manner.

15.5 Nonalienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

15.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

15.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to which they were entitled as of the date the discontinuance of contributions occurred.

15.8 Plan Interpretation. This Plan, the Summary Plan Description and the various Component Plans are intended to be read in conjunction with one another. However, to the extent of any conflict, the provisions of the Plan shall control, unless otherwise provided by Sections 125, 129 or 105(b)of the Code or the Regulations issued thereunder.

15.9 Governing Law. The Plan shall be administered in the State of California and its validity, construction, and all rights hereunder shall be governed by the laws of the State of California.

15.10 Severability. If any provision of the Plan shall be held invalid or unenforceable, the remaining provisions shall continue to be fully effective.

15.11 Gender and Number. Words used in the masculine, feminine, or neuter gender shall each be deemed to refer to the other whenever the context so requires. Words used in the singular or plural number shall each be deemed to refer to the other whenever the context so requires.

15.12 Headings. Headings used in the Plan are intended solely for reference and are not intended to explain, modify or place any construction on any of the provisions of the Agreement. Any conflict between such headings and the text shall be resolved in favor of the text.

15.13 Successors and Assigns. The Plan shall inure to the benefit of and be binding upon the parties hereto, their successors and assigns.

15.14 Discharge of Employee. The adoption and maintenance of the Plan shall not be deemed to be a contract between the Employer and the Employee. Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

15.15 Consolidation With Other Plan Documents. In the event the Plan merges or consolidates with, or transfers the assets and liabilities to, any other plan, no Participant herein shall, solely on account of such consolidation or transfer, be entitled to a benefit on the day following such event which is less than the benefit to which he or she was entitled on the day preceding such event. For the purpose of this Section, the benefit to which a Participant is entitled shall be calculated and based upon the assumption that a Plan termination and distribution of assets occurred on the day as of which the amount of the Participant's entitlement is being determined.

15.16 Counterparts. The Plan may be executed in an original and any number of counterparts by the Employer, each of which shall be deemed an original of one and the same instrument.

IN WITNESS WHEREOF, the Employer has caused this Amendment to be executed on September 10, 2008.

EMPLOYER:

RIVERSIDE COUNTY TRANSPORTATION COMMISSION

By:____
Its: Chairman

APPROVED AS TO FORM AND CONTENT:
BEST BEST & KRIEGER LLP

By: ________________________________
Attorneys for Employer

SCHEDULE "A"

The following Schedule, which may be amended from time to time by the Employer, specifies the Benefits and the Component Plans which set forth the terms, conditions and limitations of the Benefits offered to Participants. The periods of coverage for the Component Plans shall be the same as the Plan Year of the Flexible Benefits Plan, unless specified otherwise.

BENEFIT	PROVIDER	PERIOD OF COVERAGE	MAXIMUM LEVEL OF COVERAGE
Medical	CalPERS Health Benefits Program	Plan Year	N/A
Medical Reimbursement Plan	Self-insured	Plan Year	$2,500.00 annually
Dependent Care Reimbursement Plan	Self-insured	Plan Year	$5,000.00 annually $2,500.00 annually for married Participant filing separate

CERTIFICATION OF EMPLOYER TO
RIVERSIDE COUNTY TRANSPORTATION COMMISSION
FLEXIBLE BENEFITS PLAN

RIVERSIDE COUNTY TRANSPORTATION COMMISSION, is the sponsor of the RIVERSIDE COUNTY TRANSPORTATION COMMISSION FLEXIBLE BENEFITS PLAN. The Plan is a hybrid entity within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which includes non-health care and health care components. The health care components of the Plan include the following separate group health plans:

Riverside County Transportation Commission Medical Reimbursement Plan

The Plan (excluding the non-health care components) and the health care components included in the Plan are group health plans within the meaning of HIPAA (collectively, the "Plan"). The Plan and RIVERSIDE COUNTY TRANSPORTATION COMMISSION desire to exchange health information protected under HIPAA for purposes related to administration of the Plan. RIVERSIDE COUNTY TRANSPORTATION COMMISSION, acting in its capacity as plan sponsor of the Plan ("Plan Sponsor") makes the following certifications for purposes of administering the Plan as required by the "Standards for Privacy of Individually Identifiable Health Information," 45 CFR § 164.102 et seq. (the "Privacy Rule"):

The plan document of the Plan has been amended to incorporate the following provisions and Plan Sponsor agrees to:

1. not use or further disclose any protected health information ("PHI") received from the Plan (including any health insurance issuer or HMO with respect to the group health plan) except as permitted or required by the plan documents or required by law;

2. ensure that any agents or subcontractors to whom it discloses any PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. not use or disclose PHI for employment-related actions and decisions;

4. not use or disclose PHI in connection with any other benefit plan, program, or arrangement of RIVERSIDE COUNTY TRANSPORTATION COMMISSION except to the extent such other benefit plan, program or arrangement is part of an organized health care arrangement of which the Plan also is a part;

5. report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures specified in the Plan of which it becomes aware;

6. give individuals access rights to PHI in its possession in accordance with the policies and procedures of the Plan;

7. permit individuals to request amendment of their PHI in the Plan Sponsor's possession, and to make any necessary amendments, in accordance with the policies and procedures of the Plan;

8. make information available to provide any necessary accounting of disclosures of PHI in accordance with the policies and procedures of the Plan;

9. make its internal practices, books, and records relating to the use and disclosure of PHI from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Rule;

10. if feasible, to return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible; and

11. agrees to ensure that adequate separation between the Plan Sponsor and the Plan is established.

PLAN SPONSOR

RIVERSIDE COUNTY TRANSPORTATION COMMISSION

By:____________________

Print Name: Jeff Stone

Title: Chairman

Dated:____________________

PLAN

RIVERSIDE COUNTY TRANSPORTATION COMMISSION FLEXIBLE BENEFITS PLAN

By:____________________

Print Name: Anne Mayer

Title: Privacy Official

Dated:____________________

RIVERSIDE COUNTY TRANSPORTATION COMMISSION
FLEXIBLE BENEFITS PLAN

FREQUENTLY ASKED QUESTIONS

INTRODUCTION

As of September 11, 2002, RIVERSIDE COUNTY TRANSPORTATION COMMISSION ("**RCTC**") has established the Riverside County Transportation Commission Flexible Benefits Plan ("**Plan**") which allows its employees to elect to purchase certain qualified benefits based on their individual needs with pre-tax dollars. The benefits described in this booklet constitute the benefits available under the Plan and are referred to collectively in this booklet as the "Benefits."

Plan Modification/Termination

The Plan is based on RCTC's understanding of the current provisions of the Internal Revenue Code. RCTC intends to provide benefits under the Plan indefinitely. However, RCTC may change or terminate the benefits provided or the contributions you must pay for such benefits. RCTC has the right to make these changes or to terminate benefits at any time. If this occurs it will not affect any benefit to which you were entitled prior to the date of the amendment or termination.

Plan Administration

RCTC's Accounting Department will manage the Plan and will have full discretion to determine eligibility, interpret the Plan and determine whether a claim should be paid or denied in accordance with the provisions of the Plan and with governmental regulations.

BENEFITS & COVERAGE

The Plan is made possible by Section 125 of the Internal Revenue Code. Section 125 enables Employees to set aside money on a pre-tax basis to cover:

- Premiums for group health insurance
- Allowable Medical Expenses
- Dependent Care Expenses

Contributions for any group health insurance coverage offered under the Plan are deducted from your paycheck on a pre-tax basis.

In addition, you may also elect to participate in the Medical Spending Account and/or the Dependent Care Spending Account (collectively, the "**Flexible Benefit Accounts**"), whereby RCTC takes an annual amount, determined by you, from your gross pay. The annual amount that may be deducted from your gross pay for either of the Flexible Benefit Accounts is subject

to threshold limitations which are discussed later in this booklet. This money is held in a spending account for reimbursement of your eligible medical and/or dependent care expenses. After you incur eligible medical or dependent care expenses, simply submit a claim, with the required substantiating information as further described in Q-23 and Q-31, to be reimbursed from the appropriate account.

Q-1. What Benefits are Available under the Plan?

You may purchase benefits under the Plan for yourself, your spouse and your eligible dependents. You may pay for these benefits using pre-tax dollars that are automatically deducted each pay period. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Flexible Benefit Accounts are listed on the enrollment form.

The benefits from which you may choose include:

- **Premium Payment Component**. Permits an Employee to pay for his or her share of premiums under the several different health insurance plan offered through CalPERS.
- **Medical Spending Account**. Also called the Medical Reimbursement Plan. It permits an Employee to pay for his or her Allowable Medical Expenses (See Q-21) that are not otherwise reimbursed by insurance with pre-tax dollars.
- **Dependent Care Spending Account**. Also called the Dependent Care Plan. It permits an Employee to pay for his or her Employment-Related Dependent Care Expenses (See Q-25) with pre-tax dollars.

Each benefit under the Plan has separate rules governing benefits and plan administration to comply with various federal tax laws. These rules are explained in more detail in the plan documents, copies of which are available from RCTC's Human Resources Department.

Q-2. May I Elect to Purchase Health Insurance Coverage for My Domestic Partner?

Yes, group health coverage, including medical and dental benefits, is available for Domestic Partners that meet (i) the requirements of Section 297(b) of the California Family Code ("**Domestic Partner**"), and (ii) the eligibility requirements of the applicable health insurance plan. However, please note that purchasing group health coverage for your Domestic Partner may have federal tax consequences.

Under federal tax law, if your Domestic Partner does not qualify as your tax dependent for health coverage purposes, the value of your Domestic Partner's health coverage is considered a taxable benefit under the Plan. In this case, the fair market value of your Domestic Partner's coverage for the Plan Year will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2. The fair market value of Domestic Partner health coverage is determined based upon the monthly premium for single person coverage multiplied by the number of months of coverage. Although your salary reduction amounts taken from your compensation on a pre-tax basis will be used to purchase health coverage for your Domestic Partner, the value of such additional coverage will be taxable

to you as explained above.   You will also be unable to claim expenses for your Domestic Partner under the Medical Spending Account.

If your Domestic Partner qualifies as your tax dependent for health coverage purposes, then the fair market value of your Domestic Partner's health coverage will not be included in your income or be subject to federal withholding or employment taxes. You will also be able to claim Allowable Medical Expenses for your Domestic Partner under the Medical Spending Account.

California excludes Domestic Partner coverage from gross income for state income tax purposes, even if the Domestic Partner is not a tax dependent for health coverage purposes.

Q-3. **How Do I Know Whether My Domestic Partner is My Tax Dependent for Health Coverage Purposes?**

The following conditions must be met in order for your Domestic Partner to qualify as your tax dependent for health coverage purposes under federal tax law:

1. You and your Domestic Partner have the same principal place of abode for the entire calendar year;
2. Your Domestic Partner is a member of your household for the entire calendar year (the relationship must not violate local law);
3. During the calendar year you provide more than half of your Domestic Partner's total support;
4. Your Domestic Partner is not your (or anyone else's) "qualifying child" under Section 152(c) of the Internal Revenue Code ; and

If your Domestic Partner qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your Domestic Partner's health coverage treated as taxable income. To avoid taxation, you must complete and return the attached Certification of Dependent Domestic Partner Status, indicating that your Domestic Partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, RCTC cannot make this determination for you. You will be asked to complete a Certification each year at open enrollment. For any year in which RCTC does not receive a Certification from you, RCTC will assume that your Domestic Partner does not qualify as your federal tax dependent for health coverage purposes for that year.

ELIGIBILITY & ENROLLMENT

Q-4. **Who May Participate in the Plan?**

To be eligible for participation under the Plan, you must:

- Be a resident of the United States.
- Not be a temporary or contract Employee.
- Be a regular or probationary Employee.

Q-5. How Do I Enroll in the Plan?

All Participants must enroll or re-enroll during the designated Open Enrollment Period. However, if you first become eligible after January 1 of a Plan Year you may enroll within 30 days of the date you become eligible. Enrollment forms are available from RCTC's Accounting Department or the intranet.

To select the benefits you would like to purchase under the Plan, you must complete a Flexible Benefits Enrollment Form ("**Election Form**") prior to the beginning of ***each Plan Year***.

For newly eligible employees, if you fail to complete an Election Form, then you will be considered as having elected not to participate in the Plan. If you are already a participant in the Plan and you fail to complete a new Election Form for the upcoming Plan Year, then you will be deemed to have elected the same benefit options and salary reduction amounts that you elected for the prior Plan Year; however, you will not be eligible to participate in the Flexible Benefit Accounts.

Q-6. What are the "Open Enrollment Period" and the "Plan Year"?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Plan by signing and returning an individual Election Form. See Q-5. You will be notified of the timing and duration of the Open Enrollment Period, which for a Plan Year generally will be from November 1 through December 15 of the previous Plan Year.

The Plan Year is the 12 months beginning on each January 1 and ending on December 31.

Q-7. Can I Change My Elections?

During each annual Open Enrollment Period, you may change all of your benefit elections with respect to the upcoming Plan Year. Your choices are in effect for the entire Plan Year. Only under special circumstances may you apply to change an election after a Plan Year has started and make new elections for the rest of that Plan Year. These special circumstances include the following:

Change in Status

- *Marital Status*. Change in marital status (such as marriage, divorce, legal separation or annulment);
- *Number of Dependents*. Change in the number of your dependents (such as the death of your spouse or a child; the birth, adoption of or placement for adoption of a child);
- *Employment*. Change in your employment status or the status of your spouse or dependent which results in that person becoming or ceasing to be eligible under this Plan

or other benefit plan (such as the switching from part-time to full-time employment status or from full-time to part-time status by you or your spouse; termination or commencement of employment; a strike or lockout; the taking of or return from an unpaid leave of absence; or a change in work site); **however, a change in status will not be deemed to have occurred in cases where a former employee is rehired within 30 days of his or her termination**;

- *Dependent Status*. Change in dependent status (your dependent satisfies or ceases to satisfy the eligibility requirements under the Plan);

- *Residency*. Change in residence causing you to be outside the Plan's coverage area (if applicable); or

- *Medicare or Medicaid*. Entitlement to or ceasing to be entitled to Medicare or Medicaid. Changes in election must be consistent with the change in family status. For example, the birth of a child may necessitate an increase in the Dependent Care Spending Account, but not a decrease.

Changes in Cost or Coverage

Special circumstances also include cost and coverage changes to the group health plan in which you participate, such as a significant increase in the cost of your group health coverage, a significant decrease in or cessation of your group health coverage or a significant change in your group health coverage or your spouse's attributable to your spouse's employment. For these instances, however, only a change to another health plan with similar coverage is permitted.

To change your election, complete a new Election Form available at RCTC's Accounting Department or the intranet.

PARTICIPATION IN THE PLAN

Q-8. What Are the Advantages of a Section 125 Plan?

One of the advantages of a Section 125 Plan is that the employee, rather than the employer, decides which benefits he or she should receive. Consequently, a wider range of choices is offered allowing you to make the choices as to the particular benefits which fit your situation. A Section 125 Plan can significantly lower your tax burden, because you pay no federal income tax on compensation allocated to the Plan for qualified benefits. Furthermore, you do not have to pay state income taxes on this money. However, please see Q-2 for a discussion on when certain benefits provided under the Plan may give rise to federal income tax.

Q-9. How Do I Pay for Benefits under the Plan?

An Employee's election to pay for Benefits on a pre-tax or after-tax basis is made by submitting an Election Form and a Salary Reduction Agreement with the Employer (ask the RCTC Accounting Department for a copy if you have not received one). Under that Salary Reduction

Agreement, if you elect to pay for Benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Administrator). Please see Q-2 for an exception to the preceding.

Q-10. <u>How Long Can I Participate in the Plan?</u>

You can participate in the Plan as long as you remain eligible. See Q-4. To participate in the Medical Spending Account and Dependent Care Spending Account you must elect to participate in the Flexible Benefit Accounts before the beginning of each Plan Year.

Q-11. <u>What Happens if My Employment Terminates or the Plan Terminates?</u>

If your employment terminates or the Plan is terminated, then, unless you elect to continue your participation under the Plan's group health coverage, no further additions will be made to your Flexible Benefit Accounts.

However, benefits for expenses incurred prior to termination will be paid until the earlier of:

- The end of the Plan Year; or
- The account balance in your Flexible Benefit Accounts has been reduced to zero.

PREMIUM PAYMENT COMPONENT

Q-12. <u>How Does the Premium Payment Component Work?</u>

You may choose group health coverage from one of the several different health insurance plans offered through CalPERS. You share the cost of your health coverage with RCTC and your share of the premium is deducted from each paycheck. Except as discussed at Q-2, when you participate in the Premium Payment Component your share of the premium is deducted from your paycheck on a pre-tax basis. Because contribution costs are deducted from gross pay before taxes are calculated, you save tax dollars.

If the cost of medical and prescription drug coverage increases or decreases, then your payroll deduction will be automatically adjusted to reflect the change.

GENERAL INFORMATION REGARDING FLEXIBLE BENEFIT ACCOUNTS

Q-13. How Do the Flexible Benefit Accounts Work?

You may establish special accounts for two separate categories of predictable expenses: medical and dependent care. You specify on your Election Form how much you want to contribute to each account for the Plan Year. This is your annual contribution which will be deducted from your pay throughout the year. The Internal Revenue Service states that the balances of these Flexible Spending Accounts cannot be combined or used for purposes other than for which they were originally intended. That means that if you have money left over in your Dependent Care Spending Account at the end of the year, you cannot use it for medical expenses or vice versa.

Q-14. What Are the Advantages of Electing this Benefit?

There are some expenses you know you will have to pay for in the coming year; for example, new eye glasses, orthodontia services not covered by insurance or daycare for a child or an incapacitated dependent adult while you are at work. Normally, you would pay for these expenses with after-tax income. However, when you participate in the Medical Spending Account or Dependent Care Spending Account, you may set aside pre-tax earnings in special accounts to pay for these expenses.

Q-15. How Much Should I Contribute to My Flexible Benefit Accounts?

There are certain federal regulations to consider before enrolling in either of the Flexible Benefit Accounts.

- ♦ Federal regulations require that you designate how much money you wish to contribute annually to each account at the beginning of the Plan Year.

- ♦ You may change your annual contribution only if you experience a change in family status, such as marriage, divorce or the addition or loss of a spouse's income. See Q-7 for a complete list of circumstances that qualify as a change in status).

- ♦ Due to IRS regulations, you must have incurred eligible expenses for which you may receive reimbursement from the Flexible Benefit Accounts by the end of the "grace period" (See Q-16), and make a claim for such reimbursements within 3 months after the end of such "grace period", or you will lose them. Any money left in your Medical Spending Account or your Dependent Care Spending Account after all claims have been processed for that Plan Year must be forfeited. IRS regulations prohibit RCTC from returning these forfeitures directly to the Employees who forfeited the funds. Any forfeited amounts will be applied toward plan expenses.

- ♦ Money set aside for medical expenses cannot be used for dependent care expenses, or vice versa. Therefore, if you have money left over in one account that you would otherwise forfeit, you cannot use that money for other types of expenses. That is why it is important to estimate your expenses carefully.

- ♦ Once you make an election, you cannot change it until the end of the Plan Year unless you have a change in status.

- ♦ If you do not enroll in the Plan during the annual Open Enrollment Period, you must wait until the next annual Open Enrollment Period to enroll unless you have a change in status. See Q-7 for additional information.

Here are a few questions that might help you decide how much money to set aside in your Flexible Benefit Accounts:

- ♦ What is your health insurance plan deductible? Do you think you will incur enough expenses to meet it during the Plan Year?

- ♦ At what percentage does your health insurance plan pay benefits? You can pay the remaining portion with pre-tax dollars.

- ♦ What medical, prescription drug, dental or vision care expenses do you expect to incur that may not be covered under your plan? Are you or any of your dependents on long-term medication?

- ♦ How much do you expect to pay for dependent care during this Plan Year? Be sure to consider expenses for child care, elder care and care for a disabled dependent.

Q-16. <u>What is the "Grace Period"?</u>

With respect to both the Medical Spending Account and the Dependent Care Spending Account, you may be reimbursed from unused amounts remaining in your Medical Spending Account or the Dependent Care Spending Account at the end of the Plan Year for Allowable Medical Expenses or Employment-Related Dependent Care Expenses, respectively, incurred during the Grace Period. The "Grace Period" is the period occurring two months and fifteen days after the end of the Plan Year.

Q-17. <u>How Do I Get Reimbursed?</u>

Reimbursement payments under the Medical Spending Account or Dependent Care Spending Account will be made directly to you. Simply complete a Flexible Benefit Account Reimbursement Request Form ("**<u>Reimbursement Request</u>**") available from RCTC's Accounting Department or the intranet, attach a copy of your receipts, and send it to RCTC's Accounting Department. Please see Q-23 and Q-31 for additional requirements.

Q-18. <u>When Will I Receive My Reimbursements?</u>

Reimbursement Requests are usually processed twice a week. Currently, the "cut off" is Monday/Wednesday 12:00 p.m. for Tuesday/Thursday checks, respectively. Claims for

expenses incurred during the Grace Period will be processed in the order received; first to the prior Plan Year balance, if any, and then to the current Plan Year balance.

All claims for payment in any Plan Year must be made no later than 3 months after the end of the Grace Period following the prior Plan Year. Employees who terminate employment during the Plan Year will be given 3 months from their date of termination in which to submit expenses incurred prior to their termination.

Any questions regarding the administration of the Flexible Benefit Accounts should be directed to the Accounting Department and Human Resources Manager.

Q-19. <u>How Will I Know How Much I Have in My Accounts?</u>

For each Employee, a detail statement is maintained that clearly states the balance in each account. It lists the year-to-date deposits, claims submitted and claims paid, as well as any carry-over amounts. It may be requested from RCTC's Accounting Department. In addition, three months prior to the end of the Plan Year, each participating Employee will receive an Employee Account Status Report. This report is your reminder to submit any remaining claims you may have to avoid plan forfeitures.

THE MEDICAL SPENDING ACCOUNT

Q-20. <u>What Are the Advantages of Contributing to a Medical Spending Account?</u>

You choose the amount to be deducted from your gross pay, up to a maximum of $2,500.00 in any one Plan Year. This amount will be:

- ♦ Transferred to a medical spending account in equal amounts each pay period; and
- ♦ Used to reimburse you for allowable medical expenses incurred during a Plan Year. This includes any deductibles and co-payment percentages you must pay.

Q-21. <u>What Are Allowable Medical Expenses?</u>

"Allowable Medical Expenses" means those expenses defined in Section 213 of the Internal Revenue Code for diagnosis, treatment, or prevention of disease that are not otherwise used as a tax deduction by you and that are incurred on or after the date you become covered under the Plan. This includes expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed physician to qualify.

Examples of Allowable Medical Expenses:

- ♦ Acupuncture;
- ♦ Alcoholism and drug abuse treatment;
- ♦ Ambulance services;
- ♦ Artificial limb or teeth;
- ♦ Chiropractor;
- ♦ Contact lenses;

- Cosmetic surgery necessary to improve a deformity caused by congenital abnormality, accident or trauma, or disfiguring disease;
- Crutches;
- Dental treatment (non-cosmetic);
- Deductibles or co-payments for medical, dental, or vision plans;
- Eyeglasses;
- Eye surgery;
- Fertility enhancement;
- Guide dog or other animal;
- Hearing aids;
- Hospital services;
- Laboratory fees;
- Nursing home and nursing devices;
- Oxygen;
- Prescription or eligible over-the-counter drugs or insulin;
- Psychiatric care, psychoanalysis, and psychologist services;
- Stop-smoking programs, including prescribed drugs;
- Transportation expenses for, and essential to, medical care;
- Vaccinations or Immunizations;
- Weight-loss programs related to specific disease diagnosed by physician; and
- Wheelchairs.

For a more comprehensive list, contact RCTC's Accounting Department.

Q-22. <u>What Medical Expenses Are Ineligible?</u>

You will not be reimbursed for ineligible expenses. Examples of ineligible expenses are:

- Any illegal operations or treatment;
- Unnecessary cosmetic surgery;
- Babysitting, childcare and nursing services for a normal, healthy child;
- Cost of special foods taken as a substitute for a regular diet, where the special diet is not medically necessary or the taxpayer cannot show cost in excess of cost of a normal diet;
- Cost of toiletries, cosmetic and sundry items (e.g. soap, toothbrushes);
- Diaper service;
- Fees for exercise, athletic or health club membership where there is no specific health reason for needing the membership;
- Funeral expenses;
- Hair removal (electrolysis) or hair transplants;
- Premiums paid for long term care insurance;
- Maternity clothes;
- Mechanical exercise device not specifically prescribed by a doctor;
- Nutritional supplements for general well-being;
- Teeth whitening; and
- Weight-loss program for general well-being.

For a complete list of eligible and ineligible expenses, review the IRS Publication 502 available at http://www.irs.gov/pub/irs-pdf/p502.pdf or contact RCTC's Accounting Department.

Q-23. What Should I Know About Requesting a Reimbursement from the Medical Spending Account?

Allowable Medical Expenses incurred during a Plan Year will be reimbursed, up to the amount you have elected for the Plan Year, even if you have not yet accumulated that amount in your account.

Copies of receipts from service providers or the Explanation of Benefits Form from an insurance carrier must be submitted with the completed Reimbursement Request. The documentation from the service providers must contain the following information:

- Name of the provider;
- Patient name;
- Date of service;
- Description of service; and
- Amount charged.

THE DEPENDENT CARE SPENDING ACCOUNT

Q-24. What Are the Advantages of Contributing to a Dependent Care Spending Account?

The cost of dependent care can be a major expense for today's working parents. When you participate in the Dependent Care Spending Account, you may set aside pre-tax earnings to pay for dependent care expenses incurred to enable you or your spouse to work.

When you enroll at the beginning of each Plan Year, you choose the amount to be deducted from your gross pay. The maximum that can be set aside for dependent care in any one Plan Year is:

- $5,000.00 for a single Employee, or a married Employee filing a joint federal income tax return; or
- $2,500.00 for a married Employee filing a separate federal income tax return.

The amount deducted from your pay will be transferred to your Dependent Care Spending Account in equal amounts each pay period and used to reimburse you for Employment-Related Dependent Care Expenses incurred during the Plan Year.

Q-25. What Are Employment-Related Dependent Care Expenses?

"Employment-Related Dependent Care Expenses" means expenses incurred for the care of a Qualifying Dependent to enable you or your spouse to be gainfully employed. This includes:

- ♦ Charges for daily care of any of your children who are under the age of 13. Care may be provided either in or outside your home by any person except:

  - o A child of yours who is under age 19; or

  - o A person for whom you claim a federal income tax deduction.

  If care is provided outside the home by a facility that cares for more than 6 children, the facility must be licensed.

- ♦ Charges for daily care of any member of your immediate family who is physically or mentally incapable of self-care.

- ♦ Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school care and elderly care provided this care is required to enable you (or your spouse) to work. However, expenses relating to nonrefundable fees charged by a day care facility will not be eligible for reimbursement unless child care services directly related to the fee are provided.

The expenses must be incurred on or after the date you become covered under the Plan.

Q-26. <u>What if I Incur Employment-Related Dependent Care Expenses After My Participation in the Plan has been Terminated but I Still Have a Remaining Balance in My Dependent Care Spending Account?</u>

Effective as of __________________ [Please enter effective date of Amendment No. 1], if you cease participation in the Plan prior to the end of the Plan Year, whether due to termination of employment or otherwise, and you have unreimbursed contributions remaining in your Dependent Care Spending Account you may receive reimbursement for claims for post-termination Employment-Related Dependent Care Expenses incurred during the remaining Plan Year or the Grace Period (See Q-16) immediately following that Plan Year.

Q-27. <u>Who is a Qualifying Dependent?</u>

"Qualifying Dependent" for purposes of the Dependent Care Spending Account means:

- ♦ a person under age 13 who is your "qualifying child" under the Internal Revenue Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year); or

- ♦ your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Internal Revenue Code or would qualify as your dependent except that: (1) he or she has income that equals or exceeds the exemption amount; (2) he or she is married and files a joint return with his or her spouse; or (3) you (or your Spouse, if filing jointly) could be claimed as a tax dependent of another taxpayer.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Dependent with respect to the noncustodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Administrator for more information on which individuals will qualify as your Qualifying Dependents.

Q-28. <u>Can I Still Take the Federal Income Tax Credit for Dependent Care Expenses?</u>

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the Dependent Care Spending Account, although your Employment-Related Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see Q-29). For example, if you elect $3,000 in coverage under the Dependent Care Spending Account and are reimbursed $3,000, but you had Employment-Related Dependent Care Expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Dependents.

Q-29. <u>What is the Dependent Care Tax Credit?</u>

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Internal Revenue Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Employment-Related Dependent Care Expenses. For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor.

Q-30. <u>What Should I Consider When Determining if and to What Extent to Participate in the Dependent Care Spending Account?</u>

When deciding whether to set aside part of your pay for dependent care, you need to consider how the tax break for the Dependent Care Spending Account compares with the Dependent Care Tax Credit.

The Dependent Care Tax Credit is subtracted from your income tax, while the Dependent Care Spending Account reduces your taxable income. The method that gives you the greatest tax savings depends on your individual situation. In some cases, either the Dependent Care Tax Credit or the Dependent Care Spending Account may be better. In other cases, using a combination of the two may provide the most tax savings.

Q-31. What Should I Know about Requesting a Reimbursement from the Dependent Care Spending Account?

Employment-Related Dependent Care Expenses incurred during a Plan Year will be reimbursed when you have a positive, or funded, balance in your Dependent Care Spending Account for that Plan Year.

Submit an itemized receipt or canceled check, along with a completed Reimbursement Request, to RCTC's Accounting Department. The Tax ID Number (or Social Security Number) of the care provider must be included on the Reimbursement Request. The tax law requires you to give this number, and your dependent care provider is required by law to give you this number.

OTHER RIGHTS THAT YOU SHOULD KNOW

COBRA and HIPAA Rights. Under the Health Insurance Portability and Accountability Act of 1996, you have certain rights to the reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group 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 continuation coverage, when your 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.

Family Medical Leave Act. As an Employee, you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work-weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for RCTC for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse, or parent) or a personal serious health condition.

As a participant in the health care part of the Plan, you have, while on FMLA leave, the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave. You and your eligible dependents shall remain covered under the Plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify RCTC that you will not return to work. If you choose not to remain covered under the Plan while on FMLA leave, and subsequently return to work before or at the end of FMLA leave, you and your eligible dependents shall immediately become covered under the Plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave.

Continuation Coverage Following Termination of Employment. Continued health care coverage may be available to you under the terms of the component health plans. If you are covered under one of the Plan's group health plans, you have the right to choose continuation coverage if you lose health coverage for any reason other than termination due to gross misconduct. Your spouse or eligible dependent covered under a health plan shall have a separate

right to continuation coverage for themselves if they lose group health plan coverage for any of the following reasons:

- your death;
- the termination of your employment (for any reasons other than gross misconduct) or reduction in your hours of employment;
- your divorce or legal separation;
- you become entitled to Medicare; or
- the dependent ceases to be a "dependent child" under the terms of a group health plan.

The terms on which continuation coverage is available are explained in the information provided to you in connection with your enrollment in the particular health plans.

If you have a balance in either of your Flexible Spending Accounts upon your termination of employment, you may elect to continue your participation under the Plan's group health coverage until the end of the Plan Year. Your continued participation is subject to payment of required contributions on an after-tax basis. If you incur Allowable Medical Expenses during the period of continued participation, you will be reimbursed for those expenses according to Q-17. However, in no event will you receive benefits in excess of the elected salary reduction for that Plan Year.

OTHER INFORMATION TO KNOW

Qualified Medical Child Support Orders. Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan. A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Maternity and Newborn Coverage. Group health plans and health insurance carriers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Confidentiality of Your Private Health Information. A federal law, the Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires that health plans protect the

confidentiality of your private health information. Because this Plan offers certain health plan benefits, such as a medical plan, dental plan, vision plan, and medical spending account, it is required by HIPAA to safeguard your private health information. The section of the Plan relating to HIPAA will apply only to those health plan benefits provided under the Plan.

The Plan and RCTC will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates (those entities that perform functions on behalf of the Plan and need access to private health information) to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of RCTC.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was either distributed to you upon enrollment or prior to June 15, 2006. For a copy of this notice, if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the Privacy Official and Complaint Manager for RCTC.

Examination of Records. RCTC will make available to each Employee such records as pertain to the Employee, for examination at reasonable times during normal business hours.

Amendment or Termination of the Plan. RCTC, at any time or from time to time, may amend any or all of the provisions of the Plan without your consent. No amendment will have the effect of reducing any of your benefit elections in effect at the time of such amendment, unless such amendment is made to comply with federal law or local statute or regulations. RCTC reserves the right to terminate this Plan, in whole or in part, at any time.

Non-Alienation of Benefits. Except for Qualified Medical Child Support Orders received by RCTC, no benefit, right or interest of any person under this Plan will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Limitation on Employee Rights. Nothing appearing in or done pursuant to this Plan will be held or construed:

- ♦ To give any person any legal or equitable right against RCTC, except as expressly provided herein or provided by law; or

♦ To create a contract of employment with any Employee, to obligate RCTC to continue the service of any employee or to affect or modify his or her terms of employment in any way.

Other Salary-Related Plans. It is not intended that any other salary-related employee benefit plans that are maintained or sponsored by RCTC will be affected by this Plan. Any contributions or benefits under such other plans with respect to you will, to the extent permitted by law, be based on your compensation from RCTC, including any amounts by which your salary or wages may be reduced.

Jurisdiction. The Plan is governed by the Internal Revenue Code and the regulations issued thereunder (as they might be amended from time to time).

GENERAL INFORMATION

Name and Identification Number of Plans

Riverside County Transportation Commission Flexible Benefits Plan (501), Riverside County Transportation Commission Dependent Care Reimbursement Plan (502) and Riverside County Transportation Commission Medical Reimbursement Plan (503).

Participants

The plans provide benefits for all employees of RCTC who meet the eligibility requirements described herein.

Plan Administrator

Riverside County Transportation Commission
4080 Lemon Street, 3rd Floor
Riverside, CA 92501
(951) 787-7141

Contact: Michele Cisneros, Accounting and Human Resources Manager

If you have a question about the Plan, then contact RCTC's Finance Department:

Chief Financial Officer	(951) 787-7926
Accounting Human Resources Manager	(951) 787-7941
Accounting Technicians	(951) 787-7925 or 787-7959
Senior Accounting Assistant	(951) 787-7930

Employer Identification Number (EIN)

33-0072823

Agent for Service of Legal Process

Clerk of the Board
Riverside County Transportation Commission
4080 Lemon Street, 3rd Floor
Riverside, CA 92501

Plan Year

The Plan Year is based on the calendar year beginning on January 1 and ending on December 31.

Plan Definition and Funding

This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 health flexible spending account, classified by the Department of Labor as a "welfare" plan, and a Section 129 dependent care flexible spending account. The Plan is funded through salary reduction contributions.

Health Insurance Issuer

The name and address of the health insurance agent is:

CalPERS
Office of Employer & Member Health Service
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and RCTC. RCTC's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

GLOSSARY

The following defined terms have a special meaning with respect to the benefits outlined in this booklet.

"**Employee**" refers to a person in the Service of RCTC, and only includes a person who is a resident of the United States.

"**RCTC**" refers to Riverside County Transportation Commission, as the employer.

"**Service**" refers to work performed for RCTC on an active regular or probationary basis; and not as a temporary or contract employee.