

**CITY OF LEMOORE  
SECTION 125  
FLEXIBLE BENEFIT PLAN**

**AMENDMENT**

**WHEREAS**, City of Lemoore (the "Company") maintains City of Lemoore Flexible Benefit Plan (the "Plan") for the benefit of certain of its employees; and

**WHEREAS**, Pursuant to Article V Medical Reimbursement Plan, the Company desires to amend the Plan;

**NOW, THEREFORE**, the Plan is hereby amended as follows, effective as provided therein:

This Amendment to the Plan is adopted to reflect the provisions of the Patient Protection and Affordable Care Act, the Reconciliation Act (hereinafter both are collectively referred to as "PPACA") and certain other provisions of applicable law and the applicable regulations that are generally effective after December 31, 2009 ("Applicable Law"). This Amendment is intended as good faith compliance with the requirements of the PPACA and Applicable Law and is to be construed in accordance with same. This Amendment and the provisions of Applicable Law shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Amendment, PPACA and Applicable Law.

**A. OPTIONAL PROVISIONS:**

**Election Change For Children Under Age 27**

1. If Health Care Reimbursement Account contributions are permitted and the Plan provides coverage for children, does the Plan provide for a new election opportunity for newly eligible dependent coverage under the Cafeteria plan effective March 30, 2010 (Paragraph B.5)?
  - i.  Yes
  - ii.  No

**B. STANDARD PROVISIONS:**

1. No Coverage For Over The Counter Medications Without a Prescription. Effective January 1, 2011, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. To the extent provided in the Adoption Agreement, the Company may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate

payment of reimbursements available under Section 4.01 provided that the use of such card complies with IRS Notice 2010-59 and any superseding guidance.

2. Maximum Salary Reduction Amount for a Health Care Reimbursement Account. The maximum salary reduction amount that can be contributed to a Health Care Reimbursement Account in any Plan Year may not exceed the maximum permitted under Code section 125(i) (\$2,500 in 2013).
3. Qualified Benefits. As of January 1, 2014, the term "Insurance Contract" may not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employee's Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.
4. Coverage for Children up to Age 26. For purposes of Code section 105(b), expenses for a child (as defined in section 152(f)(1)) of the Participant may be covered until his or her 26th birthday although the Plan Administrator may extend coverage until the end of the calendar year in which the child turns age 26.
5. Election Opportunity for Children Under Age 27. If elected in the optional provisions, a Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a child up to age 27 became newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage; and (ii) the election change corresponds with the change in status that affects eligibility for coverage under a qualified benefits plan.
6. Coverage of Preventative Care without Cost-sharing. In the event the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the portability requirements of Code section 9801 et. Seq. The Plan Administrator shall only provide a certificate of creditable coverage if the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2. If i) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and ii) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act, then the Plan must provide coverage without cost-sharing requirements for preventative care as provided in Treas. Reg. 54.9815-2713T (and any superseding guidance; up to the amount available in the Participant's Health Care Reimbursement Account).
7. Internal and External Claims Procedure for Health Care Reimbursement Account.
  - (a) Applicability. This Section shall apply for any claim for benefits under the Health Care Reimbursement Account if 1) the Plan constitutes a group health plan as

defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and 2) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(b) **Effective Date.** This Section shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(c) **Internal Claims Process.** The claims requirements of DOL Reg. section 2560.503-1 shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719, in any superseding guidance and below.

(1) **Adverse Benefit Determination.** An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(2) **Full and Fair Review.** A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(3) **Notice.** A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(4) **Deemed Exhaustion of Internal Claims Process.** If the Plan fails to strictly adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), the claimant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA.

(d) **External Claims Process.**

(1) **State External Claims Process.** If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act then the plan must comply with the applicable State claims review process.

(2) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (d)(1) above is not applicable.

8. Dependent Care Assistance Accounts Limits. The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is \$5,000 (\$2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) shall apply in determining earned income.

PLAN YEAR END: 12/31

**IN WITNESS WHEREOF**, the Company has caused this Amendment to be executed this \_\_\_\_ day of \_\_\_\_\_, 2011.

CITY OF LEMOORE

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_