
THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

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ARTICLE I INTRODUCTION

1.1 Creation and Title.

The County of Riverside, a political subdivision of the State of California (the "County"), hereby amends its cafeteria plan under the terms and conditions set forth in this document. The Plan is to be known as The County of Riverside Flexible Benefit Program.

1.2 Effective Date.

The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2005. The Plan was originally effective November 20, 1986.

1.3 Purpose.

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

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ARTICLE II DEFINITIONS

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

- 2.1 "Benefits"** mean cash and the various qualified benefits under section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including but not limited to health plans, dental plans, vision plans, and health care reimbursement and dependent care reimbursement benefits.
- 2.2 "Benefits Accounts"** mean the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.
- 2.3 "Benefits Enrollment Application"** means the completion of paper forms and/or submission of electronic enrollment, including a Salary Reduction Agreement, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.
- 2.4 "Code"** means the Internal Revenue Code of 1986, as amended from time to time, or superseded by laws of similar effect.
- 2.5 "Compensation"** means all the earned income, salary, wages and other earnings except bonuses and overtime paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a Salary Reduction Agreement which are not includable in gross income under sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.
- 2.6 "Dependent"** means an individual who is a dependent within the meaning of section 152(a) of the Code and modified by Code sections 105 and 106 and the respective Regulations thereunder, of a Participant or a former Participant in the Plan. Notwithstanding the previous sentence, with respect to Dependent Care Reimbursement Benefits, "Dependent" shall have the meaning as set forth in the County of Riverside Dependent Care Reimbursement Plan.
- 2.7 "Effective Date"** The provisions of the Plan, originally effective as of November 20, 1986, have been amended and restated, effective as of January 1, 2005.
- 2.8 "Eligible Employee"** means an Employee, as defined in section 2.9 below, who has met the Eligibility requirements of the Plan set out in section 3.1.
- 2.9 "Employee"** means an individual employed by the Employer in a regular position, as defined in Salary Ordinance Number 440 of the County. The term Employee excludes per diem, temporary and seasonal employees, as defined in Salary Ordinance Number 440 of the County, leased employees as defined in Code section 414(n), and each individual whom the County treats as an independent contractor, even if s/he might otherwise satisfy certain of the legal tests or criteria to be considered a common law employee of the County.

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2.10 "Employer" and "County" means the County of Riverside, a political subdivision of the State of California, or any of its affiliates, successors or assignors which adopt the Plan.

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

2.12 "Participant" means any Employee who has met the eligibility requirements of section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Salary Reduction Agreement and Benefits Enrollment Application.

2.13 "Plan" means The County of Riverside Flexible Benefit Program, as described herein.

2.14 "Plan Administrator" means the Human Resources Director of the County, or such other person or committee as may be appointed by the Employer to administer the Plan.

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

2.16 "Regulation" means any applicable regulation established by the U.S. Treasury that relate to benefit plans established under Code section 125.

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

2.17 "Spending Credits" mean an amount made available to a Participant by the Employer in a Plan Year for use in purchasing Benefits available under the Plan.

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

2.19 "Status Change" means any of the following with respect to Benefits under the Plan:

- (a) Legal marital status. Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption.
- (c) Employment status. Any of the following events that change the employment status of the Employee, Spouse, or a Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer or the employer of a Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this paragraph.
- (d) Dependent first satisfies or ceases to satisfy eligibility requirements. Events that cause

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- a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) Residence. A change in the place of residence of the Employee, Spouse or Dependent.
- (f) Judgment, decree, or order. This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in section 609 of ERISA) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code section 152 (except that any child to whom Code section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan; or permit the Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child.
- (g) Entitlement to Medicare or Medicaid. If an Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Employee to make a prospective election change to cancel or reduce coverage of that Employee or Dependent under the Plan. In addition, if an Employee, Spouse or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Employee to make a prospective election to commence or increase coverage of that Employee, Spouse or Dependent under the Plan.
- (h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code section 125.

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ARTICLE III PARTICIPATION

3.1 Eligibility.

Each Employee, as defined in section 2.9 above, who is a member of a group of Employees which is:

- (a) represented for collective bargaining purposes by an association or union which adopts the Plan through a Memorandum of Understanding with the County, or
- (b) within a classification of Employees with respect to which the County adopts the Plan, shall be eligible to participate in the Plan if the Employee is eligible to participate in the Employer's health care program and so long as the Participant is employed by the Employer as of his or her Entry Date. If a Participant transfers to any position which is not covered by the Plan, s/he will cease to be a Participant. The individual will again be eligible to become a Participant when s/he returns to a position covered by the Plan.

3.2 Commencement of Participation.

An Eligible Employee shall become a Participant in the Plan after completing the Plan Administrator's executed Benefits Enrollment Application setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year or, with respect to an Employee's initial election period, the remaining portion of the Plan Year that contains the Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. An Eligible Employee must execute the Plan Administrator's Benefit Enrollment Application and a Salary Reduction Agreement, within 60 days of the Entry Date. Notwithstanding the above, any employee who fails to enroll in a medical plan sponsored by the County as required by his/her Memorandum of Understanding or Management Resolution will be automatically enrolled in County sponsored medical plan and will be deemed to have elected participation in this Plan without a Benefit Enrollment Application. A Participant may not modify his Benefits elections at any time during the Plan Year except as provided for under Section 4.3. If a Participant wants to change his elections for a forthcoming Plan Year, the Participant must, before the end of the first Plan Year of participation and, before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Application, which may be completed in paper or electronic form. Each new Benefits Enrollment Application shall specify the type and amount of Benefits to be made available to the Participant for the immediately following Plan Year. Should a Participant fail to execute a valid Benefit Enrollment Application for any Plan Year before the start of the Plan Year, the Benefits Enrollment Application for the immediately preceding Plan Year shall be deemed to be effective for the subsequent Plan Year. In addition, the Participant shall be deemed to have executed a valid Benefits Enrollment Application for purposes of determining the source and amount of contributions to the Plan pursuant to Article IV of the Plan. A Participant may also elect not to participate for a particular Plan Year by submitting an "Election to Pay Premiums with After-Tax Dollars" form prior to the start of the Plan Year. Notwithstanding the above, a Participant who fails to execute a valid Benefits Enrollment Application for any Plan Year before the start of the Plan Year with respect to participation in the County's Health Reimbursement Plan or Dependent Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

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3.3 Term of Participation.

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

- (a) the end of the month following the month in which the Participant ceases to be an Employee, resigns or terminates employment with the Employer, subject to the provisions of section 3.4;
- (b) the date the Participant fails to make required contributions under the Plan;
- (c) the date the Participant dies; or
- (d) the date the Plan terminates.

3.4 Participation by Rehired Employees.

If a terminated Employee is rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may resume participation in the Plan under the terms of the Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year.

3.5 HIPAA Portability.

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

3.6 COBRA Continuation Coverage.

Subject to any provision in the Code or Regulations governing COBRA Continuation Coverage to the contrary, COBRA type continuation shall be available to all Participants. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

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

3.7 Family Medical Leave Act.

Subject to any provision in the Code or Regulations governing Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave coverage to the contrary, FMLA-type continuation coverage shall be available to all qualifying Participants.

If the leave is paid, contributions may continue to be made under the Plan as elected under Section 3.2. Payment Options for coverage while on unpaid leave include:

- (a) Pre-pay before commencement of leave through pre-tax or after-tax Salary Reduction Agreement from any taxable Compensation, provided all other Plan requirements are met;
- or

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- (b) Pay-as-you-go. Employees may pay their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations and approved by the Plan Administrator.

If an Employee is away from work during an approved non-FMLA absence without pay, any of the above options may also be allowed.

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

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ARTICLE IV CONTRIBUTIONS

4.1 Source of Contributions.

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

4.2 Spending Credits.

Prior to the beginning of each Plan Year or a Participant's Entry Date, the Employer shall provide each Participant with an amount of Spending Credits according to the formula set forth by the Board of Supervisors prior to the beginning of the Plan Year. Each Participant shall select from among the Benefits (other than cash compensation) available under the Plan and apply Spending Credits towards the cost of the selected Benefits by either completing a Benefits Enrollment Application in paper form and returning it to the Plan Administrator, or completing an online enrollment Application. Spending Credits not applied by the Participant toward the cost of Benefits shall be paid as cash compensation, and only if the Participant elects at least one of the Benefits options and submits a Benefits Enrollment Application to the Plan Administrator. Employees electing not to take medical coverage are not eligible to receive Spending Credits unless they meet the rules regarding waiver eligibility stipulated in the Memorandum of Understanding or Management/Confidential Resolution governing their bargaining unit. They must also provide evidence of medical coverage through their Spouse or other sources, and sign a statement that they are enrolled and covered under another medical plan, within 60 days of election.

The County shall provide a composite contribution for each Employee in the amount determined by the Board of Supervisors, based on the Employee's unit/classification. Included within the monthly contribution amount is an amount that is designated as the County's monthly contribution toward the Public Employees' Medical Health Care Act (PEMHCA) or the County's optional health plans, if any.

4.3 Change in Participant's Benefits Enrollment.

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

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change, shall be effective prospectively (except for the retroactive enrollment right under Code section 9801(f) that applies to a timely election made after a birth, adoption, or placement of a child for adoption), and apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Application.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment

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period. With respect to any other change in election, "timely submitted" shall mean submitted no later than 60 days from the date of the qualifying Status Change. The Plan Administrator shall make the final determination regarding whether the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and Benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of this Plan.

4.4 Increases or Decreases in Premiums.

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

4.5 Maximum Contribution.

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

4.6 Nondiscrimination.

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

4.7 Tax Treatment.

While it is County's intent that nontaxable Benefits will be eligible for exclusion from the gross income of the Employee, the County cannot guarantee or ensure that any of the Benefits provided under the Plan will not be subject to income or other taxes.

Furthermore, the County will not be liable for any income or other taxes imposed upon an Employee, Spouse, Dependent, or any other person by reason of any Benefits received under the Plan.

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ARTICLE V
PARTICIPANTS' ACCOUNTS AND PAYMENT OF BENEFITS

5.1 Participants' Benefit Accounts.

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

5.2 Premium Account.

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

5.3 Reimbursement Account.

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

5.4 Payment of Benefits.

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

- (a) Executor of the Estate of the deceased Participant,
- (b) Spouse,
- (c) Family member held responsible for payment of deceased's medical bills,
- (d) Spouse of dependent with COBRA continuation rights.

5.5 Coverage Provided.

The provisions of each health, dental, and vision Benefit Option available under this Plan are described in the individual benefit plan descriptions. Reimbursement-type benefits are described in separate plan documents.

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**ARTICLE VI
PLAN ADMINISTRATION**

6.1 Plan Administrator.

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

6.2 Plan Administrator's Duties.

In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have such rights, duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

- (a) to construe and interpret the Plan, to decide all questions of eligibility and participation, and to determine the benefit plans and programs to be covered by this plan;
- (b) to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;
- (c) to prescribe and apply any rules or procedures to insure the orderly and efficient administration of the Plan, including procedures for making or changing elections;
- (d) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;
- (e) to develop appellate and review procedures for any Participant, Spouse, Dependent or designated beneficiary denied benefits under the Plan;
- (f) to prepare and distribute information explaining this Plan and the benefit plans and programs covered hereby in such manner as the Plan Administrator deems to be appropriate;
- (g) to request and receive from all Participants such information as the Plan Administrator shall determine to be necessary for the proper administration of this Plan;
- (h) to furnish each Participant with such reports as the Plan Administrator deems to be reasonable and appropriate;
- (i) to receive, review, and keep on file such reports and information concerning the benefit plans and programs covered by this Plan as the Plan Administrator determines to be necessary and proper;
- (j) to appoint or employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing.

The Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of section 125 of the Code.

6.3 Information to be Provided to Plan Administrator.

The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be

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limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant, Spouse or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final.

Subject to applicable state or Federal law, and the provisions of section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures.

In cases where the Plan Administrator denies a Benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive Benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of Benefits. The written denial shall be provided to the party within 30 days of the date the Benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his final decision on the reviewed claim.

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

6.6 Extensions of Time.

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

6.7 Rules to Apply Uniformly.

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

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6.8 Indemnity.

The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law, any employee of the Employer designated by the Employer or the Plan Administrator to assist in the fulfillment of the administration of this Plan, against claims resulting from any action or conduct relating to such administration, except for claims arising from gross negligence, willful neglect, or willful misconduct. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties relating to such actions, over and above those paid by any liability or insurance contract.

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ARTICLE VII GENERAL PROVISIONS

7.1 Amendment and Termination.

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

7.2 Nonassignability.

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

7.3 Medical Child Support Orders.

The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which:

- I. Relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;
- II. Is made pursuant to a state domestic relations law; and
- III. Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the plan.

Any such Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Upon determination of a QMCSO, the Plan must recognize the QMCSO by providing benefits for

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the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

7.4 Not an Employment Contract.

By creating this Plan and providing Benefits under the Plan, the Employer in no way guarantees employment for any Employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

7.5 Participant Litigation.

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

7.6 Addresses, Notice and Waiver of Notice.

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

7.7 Required Information.

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

7.8 Severability.

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

7.9 Gender and Number.

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

7.10 Applicable Laws.

The Plan is governed by the Code and the Regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

Executed this _____ day of _____, _____

Employer: COUNTY OF RIVERSIDE

Chairman, Board of Supervisors