

**CITY OF HOUSTON EMPLOYEES'  
HEALTH CARE REIMBURSEMENT ARRANGEMENT**

**(Originally Effective May 1, 2006)**

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**PREAMBLE**

Effective May 1, 1994, the City of Houston (the “City”), established the City of Houston Employees’ Section 125 Plan (the “125 Plan”) under Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”). Subsequent thereto, the 125 Plan has been amended from time to time. Effective May 1, 2006, the City desires to adopt this City of Houston Employees’ Health Care Reimbursement Arrangement (the “Arrangement”), and incorporate this Arrangement into the 125 Plan.

This Arrangement has been established to reimburse the eligible employees of the City for the cost of health care expenses incurred by them, their spouses and dependents. It is intended that the Arrangement meet the requirements for qualification under Code Section 105, and that benefits paid employees hereunder be excludible from their gross incomes by virtue of Code Section 105(b).

The City hereby adopts this Arrangement, effective as of May 1, 2006. This Arrangement forms a part of and is incorporated by reference into the 125 Plan.

**ARTICLE I  
DEFINITIONS**

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

- 1.01 “Arrangement”** means the City of Houston Employees’ Health Care Reimbursement Arrangement.
- 1.02 “Benefits”** means any amounts paid to a Participant in the 125 Plan under this Arrangement as reimbursement for Eligible Health Care Expenses incurred by the Participant during a Plan Year by him/her, his/her Spouse or his/her Dependents.
- 1.03 “Coverage Period”** means the Plan Year during which the benefits provided by this Arrangement shall be available to a Participant hereunder.
- 1.04 “Dependent”** means any individual who is a dependent of the Participant within the meaning of Code Section 152, as modified by Code Section 105(b) and Notice 2004-79 with respect to coverage for medical expenses under Code Section 213. Any child of a Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered a Dependent under this Arrangement. Any child of a Participant who is ordered to be covered pursuant to a National Medical Support Notice shall be considered a Dependent under this Arrangement.

- 1.05 “Eligible Health Care Expenses”** means an expense incurred by the Employee, or the Employee’s Dependents, on or after the effective date of the Employee’s participation herein and during the Plan Year for medical care under Code Section 213(d) (without regard to limitations contained in Code Sections 213(a) or (b)), but shall not include an expense incurred for the payment of premiums under any health insurance plan, whether or not sponsored by the City, or any expenses incurred after a Participant’s coverage under this Plan terminates. For purposes of this Arrangement, an expense is “incurred” when the Participant or beneficiary is furnished the health care or services giving rise to the claimed expense.
- 1.06 “Spouse”** means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.
- 1.07** All of the definitions set forth in Article I of the City’s 125 Plan and not otherwise defined herein shall have the same meaning in this Arrangement, and all such definitions are hereby incorporated by reference into this Arrangement.

## **ARTICLE II ELIGIBILITY**

Each Employee of the City who is eligible to participate in the City’s 125 Plan and who has properly completed and filed the salary reduction agreement included with the Enrollment Form, and elected to participate in the Health Care Reimbursement Account Benefit shall become a Participant in this Arrangement as of the date specified in the Enrollment Form.

## **ARTICLE III COVERAGE AMOUNTS AND CONTRIBUTIONS**

### **3.01 Available Levels of Benefits**

If a Participant elects to participate in this Arrangement, the Participant must complete an Enrollment Form and elect to allocate at least \$120 in Compensation to the Arrangement for the Plan Year. On the Enrollment Form, a Participant may elect to allocate up to a maximum of \$1,000 in Compensation to the Arrangement for the Plan Year. Once the Plan Year begins, the election may not be reduced or revoked unless the Employee separates from service with the City as provided in Section 4.04 of this Arrangement, or as otherwise provided in Sections 2.03 through 2.07 of the Plan. Once the Plan Year begins, the election may not be increased unless a Change in Status occurs, provided that an Employee may only increase his/her election to the extent that the election change is consistent with the Change in Status which has transpired.

### **3.02 Required Contributions**

As a condition to continued eligibility to receive benefits under this Arrangement, a Participant shall make contributions to the Arrangement corresponding to the benefit level selected.

**3.03 Payment of Contributions**

The normal mode of payment of contributions due for a Plan Year shall be by deduction from the Participant's paychecks during the Coverage Period, pursuant to the Participant's Enrollment Form.

**3.04 Return of Unused Contributions**

If the Participant revokes an election of benefits under this Arrangement by virtue of termination of employment, the Plan Administrator shall refund any portion of previously-paid contributions which may be inadvertently withheld from such Participant's compensation after the date of the Participant's separation from service.

**ARTICLE IV  
BENEFITS**

**4.01 Eligibility for Benefits**

Each Participant in this Arrangement shall be entitled to a benefit hereunder for all Eligible Health Care Expenses incurred by him/her on or after the effective date of his/her participation (and on or after the Effective Date of the Arrangement), subject to the limitations contained in Section 3.01 and this Article IV.

**4.02 Claims for Benefits**

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator, or its designee, on a form specified by the Plan Administrator, or its designee, and pursuant to the procedures set out in the City's 125 Plan. Upon receipt of a properly documented claim, the City shall pay the Participant the benefits provided under this Arrangement within the time specified for payment under such 125 Plan. A Participant may submit a claim for reimbursement for an Eligible Health Care Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and ends on the earlier of ninety (90) calendar days after the close of the Plan Year or ninety (90) calendar days from the date such Participant ceases to participate in the Plan.

The Plan Administrator, or its designee, may set a dollar limit for the minimum amount of reimbursements made; however, there shall be no such minimum requirement if the Participant's total account balance is less than the minimum.

**4.03 Required Information**

Each Participant's claim for benefits shall contain a written statement containing such information as the Plan Administrator may deem appropriate, including:

- (a) the person or persons on whose behalf Eligible Health Care Expenses have been incurred;
- (b) the nature of the expenses so incurred;
- (c) the date that the expenses were incurred;

- (d) the amount of the requested reimbursement; and
- (e) evidence that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

#### **4.04 Termination of Employment**

In the event a Participant ceases to be an Employee of the City, his/her participation in this Arrangement shall cease on the date his/her employment terminated and all contributions to this Arrangement shall cease, unless the Participant elects to continue participating as provided below. The Arrangement shall reimburse any eligible expenses (up to the amount of the Participant's annual benefit chosen pursuant to Section 3.01, less prior benefits paid during the Plan Year) that are incurred during the Plan Year period of participation that ends on the day the Participant's coverage terminates. However, no reimbursement will be made for any Eligible Health Care Expense incurred during a period for which the Participant has not paid the required contributions under the Arrangement. The Participant shall be entitled to submit a claim for reimbursement of Eligible Health Care Expenses at any time on or before the earlier of ninety (90) calendar days following the close of the Plan Year or ninety (90) calendar days from the date such Participant ceases to participate in the Plan.

Notwithstanding the foregoing provisions of this Section 4.04, upon termination of employment, a Participant may elect to continue participating in this Arrangement until the end of the Plan Year in which such Participant terminates employment by signing an authorization form provided by the Plan Administrator to have the remaining contributions for the balance of the Plan Year withheld from such Participant's final paycheck on a pre-tax basis at the COBRA contribution rate specified in Section 5.10. As provided in Section 5.07, a Participant's duration of Continuation Coverage, if Continuation Coverage is elected under Article V, will be reduced by the number of full months between such Participant's termination of employment and the last day of the Plan Year during which the Participant terminates employment, if the Participant elects to continue participating in this Arrangement as provided in this paragraph.

Notwithstanding the preceding paragraphs, the Participant (and his/her Dependents) shall have the right to elect Continuation Coverage under Article V.

### **ARTICLE V CONTINUATION COVERAGE**

#### **5.01 Continuation Coverage after Termination of Normal Participation**

During any calendar year following a calendar year during which the City has twenty (20) or more employees on a typical business day, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Arrangement upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under this Arrangement is known as "Continuation Coverage."

## **5.02 Qualified Beneficiary**

A “Qualified Beneficiary” is any person who, as of the day before a Qualifying Event, (a) is an employee of the City covered under the Arrangement as of such day (such persons are called “Covered Employees”), (b) the Spouse of the Covered Employee, or (c) a Dependent of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee’s employment. A retiree or other former employee actively participating in the Arrangement by reason of a previous period of employment will be treated as a Qualified Beneficiary.

A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Arrangement by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 5.07, below shall not be considered to be a Qualified Beneficiary.

## **5.03 Qualifying Event**

Any of the following events that would result in a loss of coverage by a Qualified Beneficiary shall be considered as a “Qualifying Event”:

- (a) death of a Covered Employee;
- (b) termination (other than by reason of gross misconduct) of the Covered Employee’s employment or reduction of hours of employment below any minimum level of hours required for participation herein;
- (c) divorce or legal separation of a Covered Employee from the Covered Employee’s Spouse;
- (d) a Covered Employee’s becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act;
- (e) a dependent child of a Covered Employee ceasing to be a Dependent; or
- (f) if a Participant is on an FMLA leave and notifies the Plan Administrator and/or the City that they will not return to work, then the Qualifying Event resulting in the loss of coverage shall be deemed to occur on the day following the date the Participant notifies the City of his/her intent not to return to work. A notification to the City that the Participant will not return to work from an FMLA leave terminates the leave for COBRA purposes on the date the notice is given to the City, thus resulting in the loss of coverage and termination of the leave on the date following the date notification of the Participant’s intent not to return to work is given to the City.

#### **5.04 Benefits Available under Continuation Coverage**

Each person who is eligible to elect Continuation Coverage under Article V shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event.

The maximum coverage amount that may be continued by the Participant or any of his/her eligible Dependents shall be:

- (a) If the Participant would have been covered under the Arrangement for a full twelve (12)-month Plan Year if his/her employment had not terminated: (i) until the end of the Plan Year in which the Qualifying Event occurs, the amount of the annual benefit that was in effect when termination occurred reduced by benefits paid out prior to termination of normal coverage, and (ii) effective as of the beginning of the next Plan Year and continuing for the months set out in Section 5.08 below, the annual coverage amount for the Participant that was in effect when termination occurred.
- (b) If the Participant would have been covered for less than a full twelve (12)-month Plan Year if his/her employment had not terminated: (i) until the end of the Plan Year in which the Qualifying Event occurs, the amount of the annual benefit that was in effect when termination occurred reduced by benefits paid out prior to termination of normal coverage, and (ii) effective as of the beginning of the next Plan Year and continuing for the months set out in Section 5.08, the annualized equivalent of the Plan Year benefit that was in effect when termination occurred.

#### **5.05 Qualified Beneficiary Notice Requirements**

- (a) In the case of a Qualifying Event described in Section 5.03(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator in writing within sixty (60) calendar days of the occurrence thereof, or if later, sixty (60) calendar days from the date the Covered Employee or Qualified Beneficiary receives the notice of the availability of Continuation Coverage, as described in 5.06(a). If the Covered Employee or Qualified Beneficiary fails to notify the Plan Administrator of such Qualifying Event within such sixty (60)-day period, such Qualified Beneficiary shall forfeit his/her right to elect Continuation Coverage under this Article V. In the event that such notice does not include all the required information, or requires clarification, the Plan Administrator shall notify the individual in writing of the deficiency and what must be done to correct the deficiency as soon as practicable. The individual will have a thirty (30)-day period beginning on the date the Plan Administrator sends written notice to respond in writing. If the individual does not respond within such thirty (30) day period, the individual's right to elect Continuation Coverage terminates on the first day following the sixtieth day following the later of the date of the alleged Qualifying Event or the date the Qualified Beneficiary receives the notice of the availability of Continuation Coverage, as described in 5.06(a).

- (b) Any Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled within sixty (60) calendar days of the Qualifying Event described in Section 5.03(b) or (f) shall provide the Plan Administrator with a copy of such determination within sixty (60) days of the receipt of such determination and within the first eighteen (18) months of Continuation Coverage. Any such Qualified Beneficiary shall notify the Plan Administrator of any determination that he/she is no longer disabled under Title II or Title XVI of the Social Security Act within thirty (30) days of such determination.
- (c) In the event a Qualified Beneficiary experiences a second Qualifying Event after commencement of Continuation Coverage under this Article V, the Qualified Beneficiary must notify the Plan Administrator in writing of the nature of the second Qualifying Event and the date it occurred within sixty (60) days of the date on which the second Qualifying Event occurred.

#### **5.06 Plan Administrator Notice Requirements**

- (a) No later than ninety (90) days after the date on which coverage commences under this Arrangement for a Participant, or his/her covered Spouse, if any, the Plan Administrator, or its designee shall provide the Participant, and his/her Spouse, if any, with a written notice of the availability of Continuation Coverage. The Plan Administrator or its designee may provide a single notice of the availability of Continuation Coverage to the Participant and the Participant's Spouse if the notice is addressed to both, and if the Plan's most recent information shows that they both reside at the same location. Notwithstanding the foregoing, a separate notice to the Spouse is required if the Participant's and Spouse's coverage does not commence on the same date, unless the Spouse's coverage commences before the Plan provides the initial notice to the Participant. In the event the Participant or their covered Spouse has a Qualifying Event within 90 days of coverage commencement under this Arrangement and prior to the delivery of the notice described in this Section 5.06(a), the Plan Administrator or its designee may satisfy the notice obligation under this Section 5.06(a) by delivering the election notice described in Section 5.06(c).
- (b) The City shall give the Plan Administrator written notice of a Qualifying Event described in Sections 5.03(a), 5.03(b), 5.03(d), or 5.03(f) above within thirty (30) calendar days of the occurrence thereof.
- (c) Within fourteen (14) calendar days of receiving a notice of the occurrence of a Qualifying Event, the Plan Administrator shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage under this Arrangement, as well as a recital of the rights of any such individual to elect Continuation Coverage. In the event that the City acts as the Plan Administrator for purposes of issuing the COBRA election notice, the City shall have forty-four (44) days from the date of the Qualifying Event in which to issue the election notice described in this Section 5.06(c). A notice to a Qualified Beneficiary who is the

Spouse or former Spouse of a Participant will be treated as notice to any child(ren) who are residing with such Spouse at the time such notice is given, provided that the most recent Plan information shows such child(ren) residing at the same address. Furthermore, a notice to both the Participant and his/her Spouse may be accomplished by a single notice addressed to both, provided that the Plan's most recent information shows that they both reside at the same address.

- (d) In the event the Plan Administrator receives a notice described in sub-paragraphs (i) through (iv), below, the Plan Administrator shall determine whether the individual is entitled to Continuation Coverage, or an extension of Continuation Coverage, as applicable. If such Continuation Coverage or an extension thereof is not available, the Plan Administrator shall provide a notice of unavailability of Continuation Coverage to the individual. Such notice shall explain the reason why the individual is not entitled to Continuation Coverage, or an extension of Continuation Coverage. The Plan Administrator shall provide the notice of unavailability of Continuation Coverage to the individual within fourteen (14) days after receiving a notice of an alleged Qualifying Event, or an event that allegedly served as the basis for an extension of Continuation Coverage.
  - (i) Notice of the occurrence of a Qualifying Event described in Section 5.03(c) or (e);
  - (ii) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to Continuation Coverage with a maximum duration of eighteen (18) or twenty-nine (29) months;
  - (iii) Notice of a determination by the Social Security Administration that a Qualified Beneficiary has been determined to be disabled under Title II or XVI of the Social Security Act during the first sixty (60) days of Continuation Coverage; or
  - (iv) Notice of a determination by the Social Security Administration that a Qualified Beneficiary no longer qualifies as disabled under Section 5.06(d)(iii) above.
- (e) In the event that Continuation Coverage of a Qualified Beneficiary terminates prior to the expiration of the maximum period of coverage described in Section 5.08 hereof, the Plan Administrator shall notify each Qualified Beneficiary of the early termination. Such notice shall include an explanation of why the Continuation Coverage terminated earlier than the maximum period available, the date the Continuation Coverage terminates, and any rights under the Plan (if any) to elect alternative group or individual coverage. This Arrangement provides for no alternative, individual or conversion coverage rights. The Plan Administrator shall furnish such notice as soon as practicable after the Plan Administrator determines the Continuation Coverage terminates prior to the expiration of the maximum period.

### **5.07 Election Period**

A Qualified Beneficiary shall have sixty (60) calendar days from the later of (i) the occurrence of a Qualifying Event, or (ii) the date of the Qualified Beneficiary's receipt of the notice described in Section 5.06(c) in which to elect Continuation Coverage under this Arrangement. Unless specified otherwise in the election, any election for Continuation Coverage by a Participant or Spouse under this Arrangement shall be deemed to be an election of Continuation Coverage on behalf of any other Qualified Beneficiary who would lose coverage under the Arrangement by reason of the same Qualifying Event.

### **5.08 Duration of Continuation Coverage**

Subject to Section 5.09, COBRA coverage timely and properly elected by any Qualified Beneficiary under this Article V shall extend for a period that begins on the date of the Qualifying Event, and ends on the earliest of the following dates:

- (a) In the case of a Qualified Event described in Section 5.03(b) or (f), Continuation Coverage shall extend for a period of up to eighteen (18) months after the date that regular coverage ceased due to occurrence of a Qualifying Event, provided however:
  - (i) if a Qualified Beneficiary is determined to have been disabled within 60 days of the Qualifying Event under Title II and XVI of the Social Security Act, then all covered family members of the disabled individual shall be entitled to an extension of the maximum period of Continuation Coverage if the Qualified Beneficiary has timely notified the Plan Administrator of such determination in accordance with Section 5.05(b). Continuation Coverage may be extended to the date which is the earlier of (i) 29 months calculated from the date of the Qualifying Event, or (ii) the first day of the month commencing more than thirty (30) days after a final determination that the Qualified Beneficiary is no longer disabled; and
  - (ii) if another Qualifying Event (other than the Qualifying Event in Section 5.03(b) or (f)) occurs during such eighteen (18) month period, and the Qualified Beneficiary has timely notified the Plan Administrator of the occurrence of the subsequent Qualifying Event in accordance with Section 5.05(c), Continuation Coverage shall be extended to the date which is thirty-six (36) months after the date of the original Qualifying Event.
- (b) In the case of an event described in Section 5.03(d), the period of coverage for Qualified Beneficiaries other than the Participant shall be extended to the date which is thirty-six (36) months after the date the Participant became entitled to benefits under Title XVIII of the Social Security Act, regardless of whether such entitlement preceded the Qualifying Event, was the sole Qualifying Event or the second Qualifying Event.

- (c) In the case of any other Qualifying Event, Continuation Coverage shall be extended to the date which is thirty-six (36) months after the date of the Qualifying Event.

#### **5.09 Automatic Termination of Continuation Coverage**

Continuation Coverage shall automatically terminate on the earliest of the following dates:

- (a) the date the City no longer offers group health coverage to any of its employees;
- (b) the date the required COBRA contributions described in Section 5.10 for Continuation Coverage is not paid within thirty (30) calendar days of the date due;
- (c) the date an electing Qualified Beneficiary first becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary other than an exclusion or limitation that does not apply to, or is satisfied by such beneficiary; or
- (d) the date an electing Qualified Beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act after electing Continuation Coverage under this Arrangement.

#### **5.10 Additional Contributions for COBRA Continuation Coverage**

The Qualified Beneficiary must make additional COBRA contributions for any period of Continuation Coverage equal to one hundred two percent (102%) of the applicable contributions, as determined in accordance with the provisions describing COBRA premiums in Code Section 4980B(f)(4) and ERISA Section 604. However, any Qualified Beneficiary, including all family members of a disabled individual who are Qualified Beneficiaries, who are entitled to extended coverage under Section 5.08(a)(i) shall be required to make additional COBRA contributions equal to one hundred fifty percent (150%) of the applicable contribution for the coverage period following the initial eighteen (18) month period. COBRA contributions shall be payable in monthly installments on the first day of every month; provided that the COBRA contribution for the period of coverage prior to the date of the Participant's initial election shall not be required prior to forty-five (45) days after the date of the election. In the event a Qualified Beneficiary makes a COBRA contribution that is not significantly less than the premium due for the COBRA Continuation Coverage, then if the amount paid is not considered payment in full by the Plan Administrator, the Plan Administrator must notify the Qualified Beneficiary of the deficiency amount and grant the Qualified Beneficiary not less than thirty (30) days after the notice is provided to pay the deficiency. An underpayment is not significantly less than the required COBRA contribution if it is no greater than the lesser of (a) \$50.00 (or such amount as the Commissioner of the Internal Revenue Service may provide in a revenue ruling, notice or other guidance published in the Internal Revenue Bulletin, or (b) 10% of the amount of the contribution the Qualified Beneficiary is required to pay under the Arrangement.

**ARTICLE VI  
BENEFIT LIMITATIONS**

**6.01 Source of Payments**

All benefits derived hereunder shall be paid exclusively from the Participant's Health Care Expense Reimbursement Account (if any) under the City's 125 Plan. The amount available for reimbursement shall, at all times during the Plan Year, be equal to the amount of coverage purchased by the Participant, less any previous reimbursements made during the Plan Year Coverage Period. However, no benefits will be payable with respect to a Coverage Period for which the Participant has not elected to participate in the Arrangement or has not made required contributions to the Arrangement.

**6.02 Dollar Limitation**

In no event may the annual value of benefits provided hereunder for any Participant pursuant to the Participant's Enrollment Form exceed \$1,000. The minimum amount that a Participant can elect to allocate to his/her Health Care Expense Reimbursement Account for the Plan Year is \$120.

**6.03 Automatic Adjustments**

Before or during the Plan Year, the Plan Administrator shall have the right to make automatic, downward adjustments to the benefit election made by any Participant who is considered to be "Highly Compensated" within the meaning of Code Section 105(h)(5) in order to prevent this Arrangement from becoming discriminatory within the meaning of Section 105(h)(4).

**6.04 Forfeiture of Unused Account Balances**

Any amount allocated to a Participant's Health Care Expense Reimbursement Account shall be forfeited by the Participant and restored to the City if it has not been applied to provide the elected Benefit for any Plan Year within ninety (90) calendar days following the end of the Plan Year for which the election was effective or ninety (90) calendar days after the date participation terminates. Amounts so forfeited shall be applied by the City to reduce future administrative costs of the City in operating the Arrangement.

**ARTICLE VII  
MISCELLANEOUS**

**7.01 Plan Administration**

The provisions of the 125 Plan as set forth in Article VI relating to the administration of the Plan, as such provisions may be amended from time to time, also shall apply to this Arrangement.

## 7.02 Claims Procedure

### (a) Initial Claim

The Plan Administrator, or its designee, shall notify the claimant within a reasonable period of time and no later than thirty (30) days after receipt of the claim of the decision on the claim. The initial period for determination on a claim may be extended one time by the Plan Administrator, or its designee, for up to fifteen (15) days provided the Plan Administrator, or its designee, both determines that an extension is necessary due to matters beyond the control of the Arrangement, and notifies the claimant prior to the expiration of the initial thirty (30)-day period of the circumstances requiring the extension and the expected date by which the Plan Administrator, or its designee, expects to render a decision. If such extension is necessary due to the need for additional information, the notice to the claimant must specifically describe the additional information needed and provide the claimant with at least forty-five (45) days in which the claimant may respond. In the event a claimant is notified of the need for additional information, the time period for processing the claim shall not begin to run again until the additional information is received from the claimant or his/her authorized representative. Any adverse benefit determination on a claim shall include the information described in Section 7.02(b) hereof.

### (b) Notice of Adverse Benefit Decision

In the event that a claim is denied, the notice of the adverse benefits decision will include the following information:

- (i) the specific reason or reasons for the adverse determination;
- (ii) reference to the specific plan provisions on which the determination is based;
- (iii) a description of any additional materials or information necessary for the claimant to perfect the claim;
- (iv) an explanation of why such information is necessary;
- (v) a description of the expedited review process for Urgent Care Claims (as described below) and applicable time limits on such review and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- (vi) in the event an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination on the claim, either a copy of such rule or guidance or a statement that a copy of the rule or

guideline, etc. will be provided to the claimant free of charge upon request.

(c) Claims Review Procedure for all Claims.

A claimant must appeal an adverse benefit determination of claim within one hundred eighty (180) days after receipt of an adverse benefit determination. The Plan Administrator, or its designee, shall render a decision on the appeal of an adverse benefit determination for a claim within sixty (60) days after receipt of the request for review.

The claimant shall receive an adverse benefit determination that includes the following information, unless other requirements are specified above. The adverse benefit determination shall include the following:

- (i) the specific reason or reasons for the adverse determination;
- (ii) references to the specific plan provisions on which the determination is based;
- (iii) a description of any additional materials or information necessary for the claimant to perfect the claim;
- (iv) an explanation of why such information is necessary;
- (v) a description of the review procedures and the applicable time limits on such review, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- (vi) in the event an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or criterion or a statement that such rule, guideline, protocol or criterion was relied upon in making the decision and that a copy of such rule, guideline, protocol or criterion will be provided to claimant free of charge upon request.

**7.03 Amendment or Termination of Plan**

The provisions of the 125 Plan as set forth in Article X relating to amendment or termination of the Plan, as such provisions may be amended from time to time, also shall apply to this Arrangement.

**7.04 General Provisions**

The provisions of the 125 Plan as set forth in Article XI relating to general provisions of the Plan, as such provisions may be amended from time to time, also shall apply to this Arrangement.

## **7.05 Participant Statements**

The Plan Administrator shall furnish each Participant with a statement of his/her Health Care Expense Reimbursement Account within ninety (90) calendar days after the close of each Plan Year. The Plan Administrator may also furnish statements to Participants more frequently.

## **ARTICLE VIII COMPLIANCE WITH PRIVACY PROVISIONS OF HIPAA**

### **8.01 Compliance with HIPAA Privacy Rule**

This Arrangement is a group health plan (as defined by 45 CFR 160.103 of the Standards for Privacy of Individually Identifiable Health Information (“Privacy Regulations”) set forth in 45 CFR Parts 160 and 164, subparts A and E), and as such, the provisions of this Article VIII shall apply to the Arrangement. All references to Protected Health Information (“PHI”) in this Article VIII refer to PHI that is created or received by the Arrangement.

### **8.02 Use and Disclosure of PHI**

The Arrangement may only use and disclose PHI as defined by the Privacy Regulations, it receives from any health plan that is a “group health plan” as defined by the Privacy Regulations, as permitted and/or required by, and consistent with the Privacy Regulations. This includes, but is not limited to, the right to use and disclose a Participant’s PHI in connection with payment, treatment, and health care operations, as such terms are defined by the Privacy Regulations, or as otherwise permitted or required by law.

### **8.03 Certification of Amendment of Arrangement by the Plan Sponsor**

This Arrangement will disclose PHI to the City, as plan sponsor of the Arrangement, only upon receipt of a certification from the plan sponsor that the documents governing the Arrangement have been amended to incorporate the provisions set forth in Section 8.04. For purposes of this Article VIII, the City is the plan sponsor.

### **8.04 Obligations of Employer Sponsoring Plan**

With respect to PHI, the City, in its capacity of plan sponsor, agrees to the following:

(a) Not use or further disclose PHI other than as permitted or required by the Arrangement or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Employer sponsoring the Arrangement provides PHI received from the Arrangement agree to the same restrictions and conditions that apply to the Employer sponsoring the Arrangement with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer sponsoring the Arrangement unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Arrangement any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- (f) Make PHI available to an individual in accordance with HIPAA's access requirements;
- (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (h) Make available the information required to provide an accounting of disclosures;
- (i) Make internal practices, books and records relating to the use and disclosure of PHI received from Arrangement available to the Secretary of the United States Department of Health and Human Services, or its designees, for the purposes of determining the Arrangement's compliance with HIPAA;
- (j) If feasible, return or destroy all PHI received from the Arrangement that the plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- (k) Establish separation between the Arrangement and the Employer sponsoring the Arrangement in accordance with 45 CFR 164.504(f)(2)(iii).

#### **8.05 Adequate Separation Between the Arrangement and the Plan Sponsor Must Be Maintained**

Only the (i) Benefits Manager, and (ii) any employee authorized in writing by the Mayor of the City to act on behalf of the Arrangement and have access to PHI shall have access to PHI.

#### **8.06 Limitations of PHI Access and Disclosure**

The persons described in Section 8.05 may only have access to and use and disclose PHI for administration functions that the City, in its capacity of plan sponsor, performs for the Arrangement.

#### **8.07 Noncompliance Issues**

If the persons described in Section 8.05 do not comply with the provisions of this Arrangement, the City shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

#### **8.08 Members of Organized Health Care Arrangement**

Any fully-insured or self-funded health plan maintained by the City shall be part of an organized health care arrangement (as defined in section 164.501 of the Privacy Regulations) with the Arrangement, but only with respect to PHI created or received by such health plans maintained by the City that relates to the individuals who are "covered persons" in such health plans.