ORDINANCE NO. 3622

AN ORDINANCE OF THE CITY OF MESQUITE, TEXAS, AUTHORIZING THE CITY MANAGER TO EXECUTE THE NECESSARY DOCUMENTS AMENDING THE TAX SAVER PLAN NECESSITATED BY CHANGES IN PROVISIONS OF THE INTERNAL REVENUE CODE; PROVIDING A REPEALER CLAUSE; PROVIDING A SEVERABILITY CLAUSE; AND DECLARING AN EFFECTIVE DATE OF JANUARY 1, 2004.

WHEREAS, with the passage of Ordinance No. 2364 on December 1, 1986, the City of Mesquite (the "City") originally adopted a Tax Saver Plan (the "Plan") that allows employees to use tax-free dollars to pay for medical or dental premiums, certain medical expenses and/or dependent care; and

WHEREAS, it has been determined that recent changes in provisions of the Internal Revenue Code have necessitated revisions to the Plan.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF MESQUITE, TEXAS:

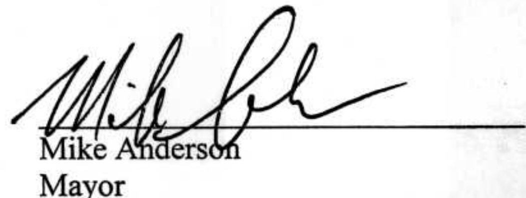
SECTION 1. That the City Manager is hereby authorized to execute the amended Tax Saver Plan attached hereto as Exhibit "A" as necessitated by changes in provisions of the Internal Revenue Code.

SECTION 2. That all ordinances or portions thereof in conflict with the provisions of this ordinance, to the extent of such conflict, are hereby repealed. To the extent that such ordinances or portions thereof are not in conflict herewith, the same shall remain in full force and effect.

SECTION 3. That should any word, sentence, clause, paragraph or provision of this ordinance be held to be invalid or unconstitutional, the validity of the remaining provisions of this ordinance shall not be affected and shall remain in full force and effect.

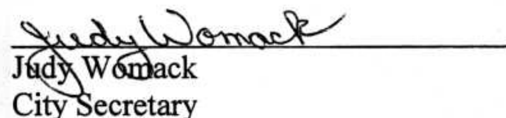
SECTION 4. That this ordinance shall take effect on and after January 1, 2004.

DULY PASSED AND APPROVED by the City Council of the City of Mesquite, Texas, on the 17th day of November, 2003.



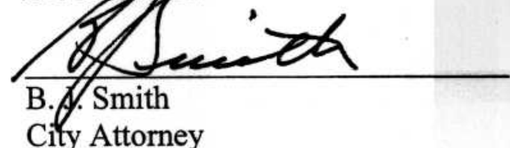
Mike Anderson
Mayor

ATTEST:



Judy Womack
City Secretary

APPROVED:



B. J. Smith
City Attorney

EXHIBIT "A"

CITY OF MESQUITE

TAX SAVER PLAN

PLAN DOCUMENT

EFFECTIVE: January 1, 2004

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ARTICLE I
GENERAL PLAN INFORMATION

Name of Plan:	**City of Mesquite Tax Saver Plan (aka Tax Saver Plan)**
Plan Sponsor / Plan Administrator: Address:	**City of Mesquite** 1515 N. Galloway Mesquite, Texas 75149
Business Phone Number:	(972) 216-6463
Participating Employer:	**City of Mesquite**
Plan Sponsor ID Number (EIN):	**75-6000606**
Plan Year:	**January 1 through December 31**
Fiduciary (Named Fiduciary): Address: (See also definition of "Fiduciary")	**Ted Barron, City Manager** 1515 N. Galloway Mesquite, Texas 75149
Designated Legal Agent: Address:	**City of Mesquite** 1515 N. Galloway Mesquite, Texas 75149

ARTICLE II
ADOPTION OF THE DOCUMENT

2.1. ADOPTION AND PURPOSE OF THE PLAN

The Plan Sponsor hereby adopts and creates by this document a plan (the "Plan") to provide certain benefits for eligible Employees of the Employer. The benefits provided by the Plan include the following:

- Pre-tax Premiums
- Health Care Expense Reimbursement
- Dependent Care Assistance

2.2. GOVERNING LAWS

It is intended that the Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that the Plan will conform to the requirements found in Section 125 of the Internal Revenue Code. If any portion of the Plan does now, or in the future, conflict with any IRS regulations which apply to this Plan, such regulations will govern.

2.3. PARTICIPATING EMPLOYERS

Employers participating in this Plan are as stated in the list of Participating Employers (see "General Plan Information," Article I).

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

ARTICLE III
SELECTION OF BENEFITS AND ELECTION MAXIMUMS

The Plan Sponsor hereby adopts the following Benefits and Benefit Maximums for the **City of Mesquite**. This schedule applies for each Plan Year beginning on or after January 1, 2004, unless a separate election form is adopted to supersede this schedule.

3.1. BENEFITS AND ELECTION MAXIMUMS SCHEDULE

BENEFITS	**Election Maximums**
Pre-tax Premiums, up to	Maximum Employee Contribution Levels
NOTE: This amount may be revised during the course of the Plan Year to the extent that required Employee contributions are changed. The Plan Sponsor reserves the right to make such a change mid-year to the extent that such change is consistent with and coincident with a coverage cost change.	
Health Care Expense Reimbursement, up to	$ 10,000
Dependent Care Assistance, up to (see NOTE)	$ 5,000
NOTE: But not more than $2,500 for a married individual filing a separate tax return. However, if Employee's spouse is either a fulltime student or incapable of self-care, the maximum is $5,000 per year.	

ARTICLE IV
INTRODUCTION

4.1. PURPOSE OF THE PLAN

The purpose of the **City of Mesquite Tax Saver Plan** is to provide each participating Employee with a means of:

- selecting from a "cafeteria" of benefits those benefits which are best suited to his/her family's needs; and
- paying for certain types of expenses with pre-tax income dollars, thus reducing his taxable income and increasing his net take-home pay.

In accordance with the requirements of Section 125 of the Internal Revenue Code, a "cafeteria plan" must offer at least one benefit option that is taxable (i.e., cash or a "cash equivalent") and at least one qualifying nontaxable benefit. The benefits being offered under this Plan include:

- **Taxable Benefits** - The taxable benefit offered by this Plan is the cash equivalent of the Plan's nontaxable benefits. That is, an Employee may choose not to participate in one or more nontaxable benefits offered by the Plan and receive his compensation on an after-tax basis.
- **Nontaxable Benefits** - Subject to the Plan's provisions and the Selection of Benefits and Election Maximums form(s) which are completed by the Plan Sponsor and incorporated by reference, an Employee will be allowed to choose among the following nontaxable benefits:
    - **Pre-tax Premiums** - within the meaning of Code Sections 106 and 79. This benefit allows an Employee to pay his share of the coverage costs for his Employer-sponsored accident, health and life coverages with Flexible Dollars.
    - **Health Care Expense Reimbursement** - within the meaning of Code Sections 105 & 213. This benefit allows an Employee to contribute Flexible Dollars to the Plan for reimbursement of health plan deductibles, his coinsurance share and certain health-related expenses.
    - **Dependent Care Assistance** - within the meaning of Code Section 129. This benefit allows an Employee to contribute Flexible Dollars to the Plan for reimbursement of dependent care expenses (i.e., child care, etc.) which enable him to be gainfully employed.

NOTE: For these purposes, "pre-tax" will mean that benefit dollars (herein referred to as "Flexible Dollars") that are placed in an Employee's Reserve Account before Federal income and Social Security taxes (as well as most state and local income taxes) are deducted from the income dollars.

4.2. SPECIAL NOTICES

Social Security - Because certain Plan benefits are paid for with pre-tax dollars, Social Security contributions and benefits may also be reduced. Other benefits which are based upon taxable compensation could also be affected - such as worker's compensation, unemployment, etc. The Employer's personnel office may be able to provide additional information as to the impact of these reductions in an individual situation.

Forfeitures - Flexible Dollars which are contributed to Reserve Accounts during a Plan Year and are not utilized for benefits during the year, must be forfeited by the Employee to the Plan and cannot be carried forward by the Employee, in any manner, to a subsequent Plan Year.

Dependent Care Credit Under Federal Income Tax - An Employee cannot claim a Federal income tax credit for any dependent care expenses which are reimbursed under the Plan.

Tax Treatment Not Guaranteed - While it is the Plan Sponsor's intent that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, neither the Plan Sponsor, the Employer nor the Fiduciaries in any way guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes.

Furthermore, neither the Plan Sponsor, the Employer nor the Fiduciaries will 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.

ARTICLE V
DEFINITIONS

When capitalized within, the following items will have the meanings shown below.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any person who submits a claim or on whose behalf a claim is submitted for benefits under the Plan.

Code - The Internal Revenue Code of 1986, as amended, and the regulations thereunder.

Covered Person - A covered Employee or a Qualified Beneficiary under COBRA. See "Eligibility and Effective Dates," Article VI, and "Continuation of Coverage Option (COBRA)," Article XIV, for further information.

Dependent - Any individual with respect to whom, for the taxable year, a deduction is allowable under Code Section 152 for Employee or Employee's spouse.

Employee - see "Eligibility and Effective Dates," Article VI.

Employer(s) - The Employer or Employers participating in the Plan as stated in "General Plan Information," Article I.

Fiduciary - Any person who has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include the Plan Sponsor.

Flexible Dollars - Those dollar amounts which an Employee may allocate to obtain benefits.

Flexible Spending Coverages - The benefits as described herein.

Key Employee - An Employee who, at any time during a current Plan Year or any of the four (4) preceding Plan Years, meets any of the following descriptions (see IRC sections 125(b)(2) and 416(i)(1)):

- an officer of the Employer having an annual compensation greater than $130,000;
- for a corporate Employer - a person:
  - who owns, directly or indirectly, more than 5% of the value of the corporation's outstanding stock or stock possessing more than 5% of the total combined voting power of all stock of the corporation; or
  - whose annual compensation exceeds $150,000 and who owns, directly or indirectly, more than 1% of the value of the corporation's outstanding stock or stock possessing more than 1% of the total combined voting power of all stock of the corporation;
- for a non-corporate Employer - a person:
  - who owns, directly or indirectly, more than 5% of the capital or profits interest in the Employer; or
  - whose annual compensation exceeds $150,000 and who owns, directly or indirectly, more than 1% of the capital or profits interest in the Employer.

NOTE: Final determination of a Key Employee will be based on the applicable sections of the Code and as it may be amended from time to time.

Highly Compensated Participant - Except as noted, an individual meeting any of the following definitions:

- an officer of the Employer whose annual compensation exceeds 50% of the annual benefit limit for defined benefits plans in effect for the given year;
- a shareholder owning more than 5% of the voting power or value of all classes of the Employer's stock;
- a highly compensated employee as may be determined based on the facts and circumstances.

NOTE: Final determination of a Highly-Compensated Participant will be based on the applicable sections of the Code (e.g., Code Section 125(e)) and as the Code may be amended from time to time.

Plan - The entity which provides the benefits described by the Plan Document, its amendments and addendums. The name of the Plan is shown in "General Plan Information," Article I.

Plan Administrator - see the definition of "Plan Sponsor" below.

Plan Document - A formal document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See "General Plan Information," Article I for further information.

Plan Year - see "General Plan Information," Article I.

Reserve Account - An individual account established by the Plan Sponsor and in the name of the Employee, for the purpose of accounting for Flexible Dollars allocated to and benefits paid under the Plan. A Reserve Account is not an interest-bearing account.

Separate accounting will be performed for each benefit elected by an Employee. Amounts attributed to one benefit cannot be transferred, in any manner, to another benefit.

Salary Reduction Agreement - An agreement between an Employee and the Employer under which the Employer reduces the Employee's salary with before-tax dollars (Flexible Dollars) and allocates them to pay Pre-Tax Premiums (if a Plan benefit) or to one or more Reserve Accounts on behalf of the Employee.

The Salary Reduction Agreement will apply only to amounts of the Employee's pay that have not been actually or constructively received by the Employee. Any amounts so elected will not become currently available to the Employee.

Each Employee may make a Salary Reduction Agreement which will reduce his salary by an amount equal to that necessary to provide for the types of benefits elected under the Plan. The amount of the salary reduction elected by the Employee will be deemed to be an Employer contribution for purposes of the Code.

The Salary Reduction Agreement will be irrevocable during the Plan Year except as provided in "Eligibility and Effective Date—Qualified Changes in Election," Section 6.4.

ARTICLE VI
ELIGIBILITY AND EFFECTIVE DATES

6.1. ELIGIBILITY

To be eligible to participate in the Plan, an individual must qualify as an Employee. An Employee is any individual who is considered to be in a legal employer-employee relationship with the Employer for Federal withholding tax purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer provided the benefit or insurance policy allows for such continuation and any required contributions are made. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n) or any self-employed individual who receives from the Employer "net earnings from self employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee. The term "Employee" shall also not include individuals covered under a collective bargaining agreement unless the collective bargaining agreement specifically provides for participation herein.

6.2. INITIAL ELECTION TO PARTICIPATE

An eligible Employee may initially elect to participate in the Plan by completing a Salary Reduction Agreement and delivering it to the Employer. An Employee will also make a beneficiary designation and an election of benefits on the form(s) provided for such purpose. In no instance can enrollment occur after an Employee begins to participate in the Plan.

In general, if an Employee fails to enroll or elects not to enroll in the Plan when initially eligible, he may not participate in the Plan until the beginning of a new Plan Year.

6.3. EFFECTIVE DATE

An Employee's participation in the Plan will be effective on the first of the month following 30 days of active employment. In no instance will coverage be effective earlier than the effective date of the Plan.

6.4. QUALIFIED CHANGES IN ELECTIONS

If an Employee has a qualified change in coverage, status or costs (e.g., due to his spouse losing or gaining employment, acquiring or losing a dependent, divorce, marriage or legal separation of the Employee, or such other events as may be permitted by the Plan Sponsor and under regulations issued by the IRS), he may change his Salary Reduction Agreement with respect to the Plan Year. See "Revocations and Qualified Changes in Elections," Section 8.2 for additional information.

6.5. ANNUAL RE-ENROLLMENT

Each Employee must complete a new enrollment form prior to the beginning of each new Plan Year if he wishes to participate in the Health Care Expense Reimbursement or Dependant Care Expense Reimbursement. If the Plan Sponsor does not receive a timely new enrollment form for an Employee's medical reimbursement or dependant care account elections, the Employee's participation in those accounts will not be renewed.

If an Employee has elected to use flexible dollars towards the payment of Pre-tax Premiums and he fails to reenroll, his prior elections for the repayment of premiums will be deemed to continue without change. If an Employee wishes to change such benefit elections or if he wishes to discontinue such participation in the Plan, he must complete a new enrollment form prior to the beginning of each Plan Year. If an Employee is eligible to participate in the Plan but fails to reenroll, his prior elections will be deemed to continue without change.

ARTICLE VII
TERMINATION OF PARTICIPATION

7.1. IN GENERAL

An Employee will cease to participate in the Plan on the earliest of the following dates:

- the date the Plan is terminated; or
- the date the eligibility requirements are no longer met, except as participation may be extended (see "Extension(s) of Coverage During Absence From Work," Section 7.3).

For **Dependent Care Expense Reimbursement**, an Employee's Reserve Account will remain open for the remainder of the Plan Year in which termination occurs. Any eligible expenses which are incurred through the end of the Plan Year may be submitted for payment from the appropriate account.

For **Health Care Expense Reimbursement**, an Employee's Reserve Account will remain open for the remainder of the Plan Year in which termination occurs but ONLY for reimbursement of expenses incurred prior to Employee's termination date, unless the Employee continues his participation as a COBRA enrollee.

7.2. EXTENSION OF COVERAGE DURING ABSENCE FROM WORK WITH PAY

If an Employee fails to continue in active employment due to vacation, sick leave, temporary layoff, or approved leave of absence, the Employee may be required to continue Flexible Dollar contributions while receiving a regular paycheck from the Employer.

7.3. EXTENSION OF COVERAGE DURING ABSENCE FROM WORK WITHOUT PAY

If an Employee is away from work on an approved leave taken in accordance with the Family and Medical Leave Act of 1993 (FMLA) or during a period of duty in the Uniformed Services (see NOTE), the following options may be available with regard to the Pre-tax Premiums and/or the Health Care Expense Reimbursement benefits. Actual available options are determined by the Plan Sponsor, subject to the RULES, below. In any case, however, the Plan Sponsor can require an Employee on FMLA leave to continue coverage(s). If Employee's contributions are not paid for such continued coverage, the Employer can require reinstatement of coverage(s) upon Employee's return from the leave and can recover the Employee's contribution share upon his return:

- **pre-payment option** – an Employee may be permitted to pre-pay his or her contribution amounts before ceasing active work (i.e., he can have his Plan contributions deducted pretax from his final paycheck or paychecks or he can pay such amounts with after-tax dollars). Prepayment with pre-tax dollars cannot extend beyond the end of the Plan Year in which the leave begins; or
- **pay-as-you-go option** – an Employee may be permitted to continue to contribute to the Plan during his leave with after-tax dollars; or
- **catch up option** – a "catch up" method may be permitted where the Employer and Employee agree in advance of the leave that this method will be used. The Employer then pays all contributions during the leave and these amounts are, in turn, repaid by the Employee on a pre-tax or after-tax basis when he returns from leave; or
- **waiver option** – the Employer may waive (suspend) Employee contribution requirements during the period of absence.

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

RULES: The following rules will apply to the options offered to an Employee with regard to continuing the Plan's Pre-tax Premiums and/or the Health Care Expense Reimbursement benefits:

- the pre-pay option may not be the sole option offered to an Employee;
- the catch-up option can be the sole option for an FMLA or active duty leave ONLY if the catch up option is the sole option offered to Employees on a non-FMLA leave;
- if the Employer offers either the pre-pay or the catch-up option during an FMLA leave, it must also offer the pay-as-you-go option if it offers the pay-as-you-go option to Employees on a non-FMLA leave.

NOTE: The "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, in active duty training, or fulltime 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.

7.4. REVOCATION AND REHIRE

If an Employee terminates, revokes his elections, and is rehired within thirty (30) days and within the same Plan Year, he must resume his original benefit elections for the balance of the year.

If an Employee terminates, revokes his elections, and returns to work more than thirty (30) days after termination but within the same Plan Year, the Employer or Plan Sponsor may: (1) refuse to allow him to participate in the Plan until the beginning of a new Plan Year, (2) allow him to resume his original benefit elections for the balance of the year, or (3) allow him to make new elections. The Employer or Plan Sponsor will treat rehired Employees in a consistent manner.

NOTE: If, within the same Plan Year, an Employee terminates and returns to work following an FMLA leave (a leave taken in accordance with the Family and Medical Leave Act), he must be permitted to choose reinstatement of any of the following which may apply: (1) pre-tax handling of contributions for group health plan coverage(s), and (2) participation in the Health Care Expense Reimbursement benefit.

ARTICLE VIII
ELECTION OF BENEFITS

8.1. BENEFITS AND BENEFIT MAXIMUMS

The benefits available under the Plan are determined at the discretion of the Plan Sponsor and are adopted on a "Selection of Benefits and Election Maximums" form. Such amounts are uniformly applicable to all Employees. All such amounts are subject to review and final approval by the Management Committee of the Plan Sponsor.

Each Employee who elects to participate completes his elections on a Salary Reduction Agreement form. The Employer reserves the right to reduce the amount of the Employee's Salary Reduction Agreement in order to assure compliance with the requirements of the Internal Revenue Code for favorable tax treatment.

NOTE: Participation in the Pre-tax Premiums benefit is contingent upon enrollment in coverages for which a pre-tax premium payment is allowed.

8.2. REVOCATIONS AND QUALIFIED CHANGES IN ELECTIONS

Employee elections for a Plan Year are irrevocable and must be made before the benefits become currently available. However, an election may be revoked or changed during a Plan Year if there is a qualified change in coverage, status or costs as permitted under Federal law. Any revocation or change must be made on account of and must be consistent with the change in status, cost or coverage.

The following is a summary of changes generally permitted under Federal law. Each Employee's individual situation, however, will need to be evaluated in terms of: (1) the Employee's existing benefit elections, (2) the Employee's status, cost or coverage changes, (3) the actual benefits included in the Plan, and (4) the law.

Change in Status - If an Employee (or an Employee's dependent as noted below) experiences a change in status during a Plan Year, the Employee may be permitted to make new elections for the remaining portion of the Plan Year. A "change in status" is a change in an Employee's (or dependent's) eligibility for coverage under a qualified benefit plan sponsored by the Employer or another employer's plan due to at least one of the following:

- an employee's gain or loss of a dependent by birth, death, adoption or placement for adoption, or where a court has issued a judgment, decree or order requiring that an Employee's dependent child or foster child be provided with health coverage;
- a change in marital status (e.g., marriage, divorce, legal separation or annulment, or the death of the Employee's spouse);
- a change in the Employee's employment status or the employment status of the Employee's spouse or a dependent (e.g., commencement or termination of employment, reduction or increase in work hours, change from salaried to hourly, a strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, etc.);
- a change in an Employee's residency or the residency of an Employee's spouse or a dependent;
- a change in the status of the Employee or one of his dependents under a plan's eligibility criteria (e.g., marriage, attainment of a specified maximum age, enrollment in or graduation from school or any similar circumstances);
- a dependent ceases to be a "qualifying individual" as that term applies to the Dependent Care Expense Reimbursement benefit;

- status changes which would permit an Employee to make mid-year changes in his Employer-sponsored health coverages in accordance with the special enrollment rights of the Health Insurance Portability and Accountability Act. A change in election status can be made under the Plan only on a prospective, and not a retrospective, basis (except for the retroactive enrollment right under Code Sec. 9801(f) that applies to an election made within 30 days of a birth, adoption, or placement of a child for adoption); or

- such other changes as may be determined to be qualified in accordance with applicable Internal Revenue Service regulations as amended from time to time and which are approved and allowed by the Plan Sponsor.

Change in Costs - If the cost charged to an Employee significantly increases or decreases during a coverage period, an Employee may make a corresponding change in his elections. These changes include starting participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for such coverage and either receiving coverage under another benefit option providing similar coverage or dropping coverage if no benefit option providing similar coverage is available.

If the cost of a qualified benefits plan increases or decreases during a Plan Year, affecting Employees' premiums for such benefit plan, the Plan may automatically make a prospective adjustment, on a reasonable and consistent basis, in the affected Employees' pre-tax premiums.

An election change with respect to the Dependent Care Expense Reimbursement benefit may be permitted due to a cost change imposed by or afforded to (i.e., in the form of a raise) a dependent care provider who is not an Employee's close relative (by blood, marriage or adoption). An election change may also be permitted if a dependent ceases to be a "qualifying individual" as defined by law.

NOTE: The "Change in Cost" rules do not apply to Health Care Expense Reimbursement elections.

Change in Coverage - If the coverage under a health plan should be significantly curtailed for all plan participants or terminated during a Plan Year and another health plan with similar coverage is available under the Plan, an Employee may elect to revoke his election and enroll under the alternative health plan.

If benefits or coverages are added to this Plan, an affected Employee may elect the new option or a replacement for a cancelled option and make corresponding election changes with respect to other options providing similar coverage.

If coverages change under a cafeteria plan or an underlying medical plan sponsored by the employer of an Employee's spouse, former spouse or dependent that results from such family member's - (1) permissible election change, or (2) new election during an open enrollment period - the Employee may change his Plan elections consistent with such changes.

If there is a change in Medicare or Medicaid entitlement by an Employee (or by the Employee's spouse or dependent), an Employee may change his Plan elections consistent with such change.

NOTE: The "Change in Coverage" rules do not apply to Health Care Expense Reimbursement elections.

An Employee who experiences a change as identified above must complete a new Salary Reduction Agreement and submit it to the Plan Sponsor within thirty (30) days of the qualified change (e.g., within thirty (30) days of the birth of a child, etc.). Election change(s), if approved, will be effective at such time as the Plan Sponsor shall prescribe, but not earlier than the first pay period beginning after the Plan Sponsor is notified, in writing, of the change in status, except as may be expressly permitted for changes requested pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

ARTICLE IX
BENEFITS

To the extent allowed by the Plan Sponsor's "Selection of Benefits and Election Maximums" for a Plan Year, an Employee may apply his Flexible Dollars toward the benefits described below.

9.1. PRE-TAX PREMIUMS

Flexible Dollars may be used for premium payments for coverage during the Plan Year under the Employer's welfare benefit plans. Premium payments will be made directly by the Employer to the plan(s). Benefits will be payable pursuant to the terms of the respective coverages (policies, etc.).

NOTE: Only the costs of coverages of such type which the Plan Sponsor offers pursuant to this Plan will be eligible for this benefit.

9.2. HEALTH CARE EXPENSE REIMBURSEMENT

Flexible Dollars may be used for reimbursement of those expenses of the Employee or an eligible Dependent which would be reimbursed under the Employer's health care coverage(s) but for the effect of a deductible amount requirement, a coinsurance provision, or a dollar limitation on the amount of the reimbursement allowable. In addition, other health-related expenses (as defined in Code Section 213, except as provided below) may be reimbursed to the extent that they are not otherwise reimbursable. To be eligible for reimbursement, the expenses must be incurred (but not necessarily billed or paid) during the Plan Year and the period of Employee's participation in the Plan.

Notwithstanding the foregoing, for all Plan Years beginning before January 1, 2004, expenses incurred for medicines and drugs will be eligible for reimbursement only if such medicines and drugs are prescribed drugs or insulin (within the meaning of Code Section 213(b)).

NOTES: This is a reimbursement benefit so proof of payment must be provided to the claims office prior to any reimbursement.

Any expense which is claimed as a Federal income tax deduction is NOT eligible for reimbursement with Flexible Dollars.

9.3. DEPENDENT CARE ASSISTANCE

Flexible Dollars may be used for the reimbursement of Dependent Care Assistance Expenses which are actually incurred during the Plan Year to care for a Qualifying Child Dependent or a Qualifying Individual AND which enable the Employee to be gainfully employed. If the Employee is married, the spouse must also work, must be a full-time student at a qualified educational institution during each of five (5) calendar months during the taxable year, or must be physically or mentally handicapped (i.e., unable to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder which has been diagnosed by a physician as a permanent and continuing condition).

If dependent care expenses are incurred for services provided outside the Employee's household by a Dependent Care Center (as defined in Code Section 21(b)(2)(d)), they will be deemed to be eligible only if the care is provided to a Qualifying Child Dependent or a Qualifying Individual who regularly spends at least eight (8) hours in the Employee's home and such center meets all applicable laws and regulations of the appropriate state or unit of local government.

Amounts paid or incurred by an Employee will not be Dependent Care Assistance Expenses within the meaning of this subsection if such amounts are paid to an individual with respect to whom, for the Plan Year, a deduction is allowable under Code Section 151(c) to such Employee or the spouse of such Employee, or a person who is a child of such Employee (within the meaning of Code Section 151(c)(3)) and who is under the age of 19 at the close of the Calendar Year.

In the case of an Employee who is married, the Plan Sponsor reserves the right to require that the Employee provide a statement of his/her spouse's Earned Income in order to participate in the Dependent Care Assistance benefit or at the time of any claim. The Plan Sponsor may also require Employees to submit such other information which the Plan Sponsor deems necessary or desirable to implement the Dependent Care Assistance program.

The Plan Sponsor will furnish to each Employee, annually on or before January 31, a written statement showing the amounts reimbursed from his/her Dependent Care Assistance Reserve Account during the preceding Calendar Year.

NOTE: An Employee may not receive in any Plan Year in excess of the lesser of: (i) Employee's Earned Income for the Plan Year, or (ii) the Earned Income of Employee's spouse for the Plan Year, with marital status determined at the close of the taxable year. For purposes of this subsection, an Employee's spouse who is either a Student or incapable of caring for himself, will be deemed to have Earned Income as provided for in Code Section 21(d)(2).

For the purposes of this benefit, the following terms will have the meanings shown below:

Dependent Care Assistance - The provisions of the Plan which constitute a dependent care assistance program within the meaning of Code Section 129.

Dependent Care Assistance Expenses - Household services and expenses for the care of a Qualifying Individual within the meaning of Code Section 21(b)(2) which are performed to enable an Employee to remain gainfully employed and which are performed: (i) in the home of the Employee; (ii) outside the home of the Employee for the care of a Dependent of the Employee under the age of 13, (iii) outside the home of the Employee for a Qualifying Individual who regularly spends at least eight (8) hours a day in the Employee's home, or (iv) outside the home of an Employee for the care of a Qualifying Individual in a Dependent Care Center.

Services may not be rendered by: (i) a dependent of the Employee or (ii) a dependent of Employee's spouse or (iii) a child, within the meaning of Code Section 151(c)(3), under the age of 19 at the close of the taxable year.

Dependent Care Center - As provided by Code Section 21(b)(2)(C) and (D): a facility which: (i) complies with all applicable laws and regulations of the state and town, city or village in which it is located, (ii) provides care for more than six (6) individuals (other than individuals who reside at the facility), and (iii) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

Earned Income - As provided in Code Section 32(c)(2), all income derived from wages, salaries, tips, other employee compensation and earnings from self-employment (within the meaning of Code Section 1402(a)); but not including any amounts paid or incurred (i) as a pension or annuity, or (ii) by the Employer for Dependent Care Assistance to the Employee.

Qualifying Child Dependent - A dependent of the Employee who is under age 13 and with respect to whom the Employee is entitled to a deduction under Code Section 151(c).

Qualifying Individual - (1) Any relative or household member who is supported by the Employee (receiving over 50% of support) and who is physically or mentally incapable of self-support; and, (2) a spouse who is physically or mentally incapable of self-support.

Student - As provided in Code Section 21(e)(7), an individual who, during each of five (5) calendar months during the taxable year, is a full-time student at an educational institution which normally maintains a regular facility and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on, as provided in Code Section 21(e)(8) and 170(b)(1)(A)(ii).

ARTICLE X
ADDITIONAL PROVISIONS

10.1. BENEFICIARY DESIGNATION

Each Employee shall designate upon such forms as may be provided for the purpose, a beneficiary or beneficiaries for their life insurance policy through the Employer. Such person or persons will automatically be designated the beneficiary or beneficiaries who are to receive, in the event of the Employee's death, payment of a reimbursement to which he is entitled under the Plan. The designation of a beneficiary will not be effective for any purpose unless and until it has been filed with the Plan Sponsor. In the event that an Employee fails to designate a beneficiary in the specified manner, or if for any reason such designation is legally ineffective or if such beneficiary predeceases the Employee or dies simultaneously with him, then, for the purposes of the Plan, distribution will be made by the Plan to the Employee's spouse (if any). If there is no spouse, at the discretion of the Plan the benefits will be paid to either: (1) any one or more of the persons comprising the group consisting of the Employee's descendants, the Employee's parents, or the Employee's heirs-at-law, and the Plan may pay the entire benefit to any member of such group or apportion such benefit among any two or more of them in such shares as the Fiduciaries, in their sole discretion, shall determine, or (2) the estate of the deceased Employee. The Fiduciaries may elect to have a court of applicable jurisdiction determine to whom a payment or payments will be paid.

In the event that an Employee is survived by a spouse, payment will be made to another beneficiary only in the event the surviving spouse consents in writing to the payment to the other beneficiary and such election is witnessed by either a notary public or a Plan Fiduciary.

See "Submitting a Claim," Sections 11.1 and 12.1, for information on filing a claim for reimbursement, whether filed by an Employee or his beneficiary.

10.2. NON-DISCRIMINATION

It is intended that the Plan will comply with all Federal tax law requirements necessary to obtain the tax benefits of a cafeteria (Section 125) plan, including the requirements that the Plan not discriminate in favor of certain Key Employees or Highly Compensated Participants as those terms are defined in the Code with regard to Section 125 cafeteria plans. See also "Definitions," Article V. Therefore, the salary reduction amounts available to such participants may be limited or reduced to assure compliance and non-discrimination. See also "Exclusion from Income," Section 10.4.

10.3. EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account(s) of any Employee, or the amount of distributions made or to be made to an Employee or other person, the Plan Sponsor will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Employee or other person the credits to the account or distributions to which he is properly entitled under the Plan.

10.4. EXCLUSION FROM INCOME

It is the intention of the Plan Sponsor that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, as provided in Code Section 125, and all provisions of the Plan will be construed in a manner consistent with that intent.

HOWEVER, neither the Plan Sponsor, the Employer nor the Fiduciaries in any way guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes. Furthermore, neither the Plan Sponsor, the Employer nor the Fiduciaries will 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.

ARTICLE XI
CLAIMS PROCEDURES FOR DEPENDENT CARE ASSISTANCE

11.1. SUBMITTING A CLAIM

To file a claim for reimbursement from his Dependent Care Assistance Reserve Account, an Employee must complete a claim form. Claims forms are available from the Employer, Plan Sponsor or claims office. The Employee will also be required to furnish such documents, evidence, data or information in support of his claim (bills or other proof of payment, etc.) as the Plan Sponsor or claims office considers necessary. The Plan Sponsor will only accept an Employee's cancelled check as proof of payment if the check is attached to an itemized bill or receipt.

Claims for expenses related to a Plan Year must be submitted not later than the 90th day after the end of the Plan Year. Claims should be forwarded to:

> **City of Mesquite**
> Human Resources Department
> 1515 N. Galloway
> Mesquite, Texas 75149

Failure to submit claims during the required period will deprive an Employee of reimbursements to which he might otherwise be entitled.

11.2. PAYMENT OF CLAIMS

Payment of covered claims will be made directly to the Employee, or to the designated beneficiary in the case of the Employee's death.

All Plan reimbursements will be subject to the following limitations:

- the maximum amount of reimbursement will not exceed the lesser of: (i) the benefit allowed by the appropriate section of the Code, (ii) the amount elected by the Employee on the election of benefits and Salary Reduction Agreement form(s), or (iii) the amount available in the Employee's Reserve Account at the time of reimbursement;

- reimbursement will be made only in the event and to the extent that such reimbursement or payment: (i) is not reimbursable under any other plan or policy, and (ii) will not be claimed by the Employee as a deduction for Federal income tax purposes.

11.3. APPEAL PROCEDURES

If a claim is wholly or partially denied, the Employee will be given written notification of such denial. This notice will include:

- the reason(s) for the denial;

- specific reference to the Plan provision(s) on which the denial is based;

- a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

- appropriate information as to the steps to be taken if the Employee wishes to submit the claim for review.

An Employee may request a review of his claim, provided such request is filed in writing to the Plan Sponsor (at the address shown above) within sixty (60) days after the date his claim is denied.

At such time as the Employee requests a review of the denied claim, he may review any pertinent documents and should submit issues and comments in writing.

The Plan Sponsor will make a decision with regard to the appeal not later than sixty (60) days after the receipt of the request for review, unless special circumstances require an extension of time. If an extension is required, written notice of the extension will be furnished to the Employee prior to the termination of the initial 60-day period. The extension notice will explain the special circumstances requiring an extension and the date the Plan Sponsor expects to render the final decision.

The decision on review will be in writing, will include the specific reason(s) for the decision and will reference the pertinent provisions on which the decision is based.

ARTICLE XII
CLAIMS PROCEDURES FOR HEALTH CARE EXPENSE REIMBURSEMENT

12.1. SUBMITTING A CLAIM

To file a claim for reimbursement from his Reserve Account for health care expenses, an Employee must:

- have elected automatic reimbursement of his expenses; or
- complete a claim form. Claims forms are available from the Employer, Plan Sponsor or claims office. The Employee will also be required to furnish such documents, evidence, data or information in support of his claim as the Plan Sponsor or claims office considers necessary.

The Employee will also be required to furnish such documents, evidence, data or information in support of his claim as the Plan Sponsor or claims office considers necessary. A claim for reimbursement of health care expenses must be accompanied by a written statement from an independent third party stating that the health care expense was incurred and its amount. Usually, the provider's itemized bill will suffice. Additionally, the Employee must provide a written statement that the expense has not been reimbursed and is not reimbursable under any other health plan and will not be claimed as a Federal income tax deduction.

Claims for expenses related to a Plan Year must be submitted not later than the 90th day after the end of the Plan Year. Claims should be forwarded to the following claims office which is responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin:

City of Mesquite
Human Resources Department
1515 N. Galloway
Mesquite, Texas 75149

Failure to submit claims during the established period will deprive an Employee of reimbursements to which he might otherwise be entitled.

12.2. CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of material needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant - see definition of "full notice" below. Claimant has at least 45 days to provide required information.
Plan Receives Complete Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant – see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.

Claimant Appeals	See "Appeal Procedures," Section 12.5.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

In the case of any extension as outlined above, the notice of extension which is provided to the Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the claims office requires additional information of the Claimant, the claims office must afford the Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Claimant until the date on which the response to the request for additional information is made.

A. Administrative Processes and Safeguards

The Plan requires that claims determinations be made in accordance with governing documents of the Plan and that they be applied consistently with respect to similarly situated Claimants. The claims procedures will not be administered in a way that unduly inhibits or hampers the initiation or processing of claims or claims appeals.

B. Authorized Representative May Act for Claimant

Any of the above actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

C. Benefit Determinations

Upon receipt of a written claim for benefits and pursuant to the procedures described herein, the claims office will review the claim submission, proof of claim, and all associated and/or applicable information provided by the Claimant and gathered independently by the claims office in light of the Plan Document through which benefits of the Plan are paid. Further, the claims office will assure that all benefit determinations are applied consistently to similarly-situated Plan participants by maintaining appropriate claim and benefit records which shall be reviewed periodically and on a case-by-case basis to determine past practices in similar claim situations. Documentation of such reviews shall be made available to the Employee upon request. Should the claims office at any time during it's review period determine that additional information is required from the Claimant, the claims office will request such necessary information. The claims office will make every effort to make its benefit determination in as reasonable a time frame as possible.

D. Calculating Time Periods

For benefit determination, the period of time within which such determination is required begins at the time a claim is filed in accordance with the Plan's reasonable procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that an extended period of time is permitted due to an Employee/Claimant's failure to submit necessary information, the period for making the determination will be tolled (suspended) from the date on which the notification of the extension is sent to the Employee/Claimant until the date on which the Employee/Claimant responds to the request for additional information.

E. Written or Electronic Notices

The Plan shall provide an Employee/Claimant with written or electronic notification of any benefit reduction or denial.

12.3. PAYMENT OF CLAIMS

Claims payments will be made directly to the Employee, or to the designated beneficiary in the case of the Employee's death.

All Plan reimbursements will be subject to the following limitations:

- the maximum amount of reimbursement will not exceed the lesser of: (1) the amount of benefit allowed by the appropriate section of the Code, or (2) the amount elected by the Employee on the election of benefits and Salary Reduction Agreement form;
- reimbursement will be made only in the event and to the extent that such reimbursement or payment: (i) is not provided for under any insurance policy, whether the premium on such policy is paid by the Employer or the individual Employee, (ii) is not provided for or reimbursable under any other plan or policy, and (iii) will not be claimed as a deduction for Federal income tax purposes.

12.4. CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Employee/Claimant will be given written or electronic notification of such denial within the time frames required by law (see "Claims Time Limits and Allowances," Section 12.2). The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- the specific reason(s) for the decision to reduce or deny benefits:
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision. Where a Plan utilizes a specific internal rule or protocol, the notice may either set forth the protocol or include a statement that a copy of such protocol will be furnished to the Employee/Claimant or his authorized representative free of charge and upon request;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan's procedures and time limits for appealed claims.

NOTE: A claim denial, or an "adverse benefit determination", means any of the following: a denial, reduction (which includes any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim), termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's eligibility to participate.

12.5. APPEAL PROCEDURES

A. Filing an Appeal and Appeal Review

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker (an appropriate Named Fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of the initial decision-maker) and he may submit new information (comments, documents, records, etc.) in support of his appeal.

In response to his appeal, the Employee/Claimant is entitled to a full and fair review of the claim and a new decision and not simply a review of whether the initial decision was reasonable. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Employee/Claimant relating to the claim. At such time as the Employee/Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits, without regard to whether the Plan relied on the material. The Plan will also disclose the names of any medical or health professionals consulted as part of the claim process, whether or not such information was submitted or considered in the initial benefit determination.

B. Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame (see "Claims Time Limits and Allowances," Section 12.2). If special circumstances which are out of the Plan's control, require an extension of time, written notice of the extension will be furnished to the Employee/Claimant prior to the termination of the initially-allowed time. The extension notice will explain the special circumstances requiring an extension and the date the Plan expects to render the final decision.

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Employee/Claimant and will include:

- the specific reason(s) for the decision;
- reference to the pertinent Plan provisions on which the decision is based; a statement that the Employee/Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. "Relevant" information includes a document, record or other information which: (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon, or (3) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination. The Plan will also disclose any documents that were created or received by the Plan during the appeal process; identification of any medical or vocational experts whose advice was obtained in connection with the initial claim denial, whether or not the advice was relied upon in making the initial decision; and
- identification of and access to any guidelines, rules, protocols which were relied upon in making the decision. Where a Plan utilizes a specific internal rule or protocol, the notice may either set forth the protocol or include a statement that a copy of such protocol will be furnished to the Employee/Claimant or his authorized representative free of charge and upon request.

ARTICLE XIII
FUNDING AND ADMINISTRATIVE PROVISIONS

13.1. FUNDING – SOURCES AND USES

A. Sources of Funds

Contributions for the Flexible Spending Coverages will be provided by the Employer on behalf of an Employee through the election of benefits and Salary Reduction Agreements. The annual election amount(s) to be deposited to Reserve Accounts will be deducted from the Employee's salary in equal amounts per pay period and are paid from the general assets of the Plan Sponsor.

All contributions must be used within the Plan Year during which the contributions were made or they will be forfeited by the Employee to the Plan.

B. Uses of Funds

The contributions will be applied to provide the benefits under the Plan. Unused (forfeited) contributions may not be carried forward by the Employee in any manner to a subsequent Plan Year. The Plan Sponsor in its sole discretion, however, may use forfeited amounts to: (1) pay administrative expenses; (2) reduce Reserve Account contributions for the following Plan Year; (3) increase amounts available to pay claims from Reserve Accounts in future years; or (4) provide a rebate to Plan participants, in which case funds must be allocated on a reasonable and consistent basis and cannot be allocated based on claims experience.

13.2. ADMINISTRATIVE PROVISIONS

A. Administration

The benefits of the Plan are administered by the Plan Sponsor.

B. Amendment or Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

With the exception of forfeited amounts, Plan funds will not at any time be used for or diverted to purposes other than for the exclusive benefit of Employees or their beneficiaries, and no amendment (aside from an amendment to terminate the Plan) will divest any person of his interest therein, except as may be required by the Internal Revenue Service or other governmental authority, or give any person any assignable or exchangeable interest or any right or thing of exchangeable value in advance of the time distribution is to be made to such person, except as otherwise permitted by law.

NOTE: Any termination, suspension, withdrawal, amendment or modification will be done in writing, and by resolution of a majority of the City Council Members of the City of Mesquite, Texas.

C. Annual Statements

If required by law, the Plan Sponsor will furnish to each Employee within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

D. Anticipation, Alienation, Sale or Transfer

No benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

E. Discrepancies

In the event that there may be a discrepancy between the booklet(s) provided to Employees (the "Summary Plan Description") and the Plan Document, the Plan Document will prevail.

F. Entire Contract

The Plan Document, any amendments and addendums, the individual applications, if any, and Salary Reduction Agreements of Covered Persons will constitute the entire contract between the parties.

G. Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

H. Fiduciary Responsibility, Authority and Discretion

Fiduciaries shall discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan. The Fiduciaries shall administer the Plan and shall have the authority to exercise the powers and discretion conferred on them by the Plan and shall have such other powers and authorities necessary or proper for the administration of the Plan as will be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries may adopt such rules and procedures for the administration of the Plan as they shall consider advisable and shall have discretionary authority to interpret the terms of the Plan and Plan Document and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) as in their opinion may be desirable for the administration of the Plan, and may pay any such person reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan.

I. Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

J. Gender and Number

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

K. Illegality of Particular Provision

The illegality of any particular provision of the Plan Document will not affect the other provisions, but the Plan Document will be construed in all respects as if such invalid provision were omitted.

L. Legal Actions

No Employee or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document. No action may be brought for benefits provided by the Plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one year after the date of such decision.

M. Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Plan Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee shall make a good faith attempt to assist the Plan in such recovery.

The Plan Sponsor may, in its sole discretion, pay benefits for expenses covered hereunder pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder.

N. Rights Against the Plan Sponsor

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its directors or officers, or as giving any person the right to be retained in the employ of the Employer.

O. Titles or Headings

Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

P. Unclaimed Accounts

If the Plan is unable, within two years after any amount becomes due and payable from a Reserve Account to an Employee or beneficiary, to make payment because the identity or whereabouts of such person cannot be ascertained, the Plan Sponsor may mail a notice by registered mail to the last known address of such person outlining the action

described in this section to be taken unless such person makes written reply to the Plan Sponsor within 60 days from the mailing of such notice. The Plan Sponsor may direct that such amount and all further benefits with respect to such person will be discontinued and all liability for the payment will terminate; however, in the event of the subsequent reappearance of the Employee or beneficiary prior to termination of the Plan, the benefits which were due and payable and which such person missed will be paid in a single sum.

ARTICLE XIV
CONTINUATION OF COVERAGE OPTION (COBRA)

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985, during any Plan Year during which the Employer has more than twenty (20) Employees, a Continuation of Coverage Option will be available when health care coverages under the Plan would otherwise terminate. This provision is intended to comply with that law, and, if it is found to be incomplete or in conflict in any way with the law and its amendments, the law will prevail.

NOTES: The COBRA option is also intended to comply with the Health Insurance Portability and Accountability act of 1996. If this provision is found to be incomplete or in conflict in any way with that law and its amendments, the law will prevail.

For Health Care Expense Reimbursement Benefits, COBRA need not be offered to a Qualified Beneficiary who has overspent his account as of the date of the Qualifying Event. Also, although COBRA must be offered to a Qualified Beneficiary who has an account balance at the time of a Qualifying Event, it can be terminated at the end of the year in which the Qualifying Event occurred.

14.1. DEFINITIONS

Qualified Beneficiary - An Employee who was participating in the Plan on the date preceding the date on which the Qualifying Event occurred.

Qualifying Event - Any one of the following which would result in the loss of coverage under the Plan:

- the termination of the covered Employee (other than by the Employee's gross misconduct);
- reduction in a covered Employee's hours of employment to an ineligible status.

14.2. NOTIFICATION

Employer must notify Employee of Continuation of Coverage rights in event of Employee's termination or reduction of hours. Notice mailed to the Qualified Beneficiary's last known address will be considered adequate. Notification must be made to Qualified Beneficiaries within 14 days of Employer's notice of the occurrence of Qualifying Event.

14.3. ELECTION AND ELECTION PERIOD

Continuation of Coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

- sixty (60) days after coverage ends due to a Qualifying Event;
- sixty (60) days after the Qualified Beneficiary receives notice of the Continuation of Coverage Option rights.

14.4. EFFECTIVE DATE OF COVERAGE

Continuation of Coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event and Qualified Beneficiary will be retroactively charged for coverage accordingly.

14.5. LEVEL OF BENEFITS

Continuation of Coverage hereunder will be equivalent to coverage provided to a similarly situated person to whom a Qualifying Event has not occurred. If coverage is modified to similarly situated Employees, the same modification will apply to Qualified Beneficiaries.

14.6. COST OF CONTINUATION OF COVERAGE

The cost of coverage may be paid in monthly installments and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. The additional 2% charge is to cover administrative costs and is not added to Reserve Account balances. Retroactive payments must be paid by the Qualified Beneficiary to the Plan within 45 days of election of Continuation of Coverage hereunder.

NOTE: In most instances, COBRA contributions will have to be paid with after-tax dollars.

14.7. TERMINATION OF CONTINUATION OF COVERAGE

Coverage under this provision will terminate on the occurrence of the earlier of:

- the termination of all Employer-provided group health plans;
- the failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is more than 30 days delinquent in paying his/her contributions);
- the date the Qualified Beneficiary becomes covered under any other group health plan as a result of employment, re-employment or remarriage, which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary; or
- the date the Qualified Beneficiary becomes entitled to Medicare benefits.

ARTICLE XV
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

15.1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The following terms shall have the following meanings:

Business Associate - shall have the meaning set forth under 45 CFR Sec. 160.103.

Protected Health Information or PHI - means information that pertains to the past, present or future physical or mental health or condition of an individual (or to the provision of or payment for health care) where such information identifies the individuals (or contains components that could reasonably be used to identify the individual).

The Plan will use PHI only as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, to the extent not inconsistent with the regulations issued under HIPAA, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care (as described in subsection (c) below) and health care operations (as described below).

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment and improvement activities;

- population-based activities relating to improving health or reducing health care cost, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

- rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

- business management and general administrative activities of the Plan, including, but not limited to:

  - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; and

  - resolution of internal grievances.

15.2. PARTICIPANT AUTHORIZATION

In addition to the uses and disclosures set forth under Section 15.1 above, the Plan will use and disclose PHI as required by law and also as permitted by written authorization of a participant or Dependent.

15.3. RESTRICTION ON DISCLOSURE TO PLAN SPONSOR

Except as otherwise permitted or required by law, the Plan and its Business Associates, health insurance issuers and HMOs, will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Employer that the Plan has been amended to incorporate the provisions of Sections 15.4 through 15.7 below.

15.4. PRIVACY AGREEMENTS OF THE PLAN SPONSOR.

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the plan document or as required by law;

- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirement;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; if feasible, return or destroy all PHI received from the Plan 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
- ensure that there is adequate separation between the Plan and the Plan Sponsor by implementing the provisions of Sections 15.5 through 15.7 below.

15.5. EMPLOYEES WITH ACCESS TO PHI

In addition to legal counsel, only the following employees or other individuals under the control of the Plan Sponsor may be given access to PHI received by the Plan Sponsor from the Plan (or its Business Associates, health insurance issuers and HMOs):

- Human Resources Director; and
- Human Resources staff designated by those individuals specified above.

15.6. LIMITATIONS OF PHI ACCESS AND DISCLOSURE.

The persons described in Section 15.5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

15.7. NONCOMPLIANCE ISSUES

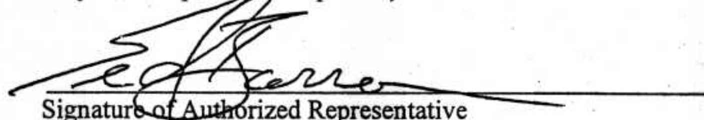
If any person described in Section 15.5 does not comply with this Article, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

15.8. SCOPE AND EFFECTIVE DATE

This Article applies only to group health plans that are included within the Plan and is effective as of April 14, 2003.

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2004.

City of Mesquite (Plan Sponsor)



Signature of Authorized Representative

City Manager

Title of Authorized Representative

Approved as to form:

Assistant City Attorney

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