

LOS RIOS COMMUNITY COLLEGE DISTRICT FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Los Rios Community College District (the "Company") established the Los Rios Community College District Flexible Benefit Plan (the "Plan") effective April 1, 1994. This Summary Plan Description describes the Plan as amended and restated effective January 1, 2014.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are employed by Los Rios Community College District or any affiliate who has adopted the Plan.

Regular employee

Regular employees working less than 50% of a full-time schedule receive a prorated employer contribution for health insurance

Adjunct employees may participate in the premium benefits offered under the Plan

COBRA participants may participate in the Plan (limited to COBRA under Medical FSA or a Limited Use Medical FSA)

However, you are not an "Eligible Employee" if you are any of the following:

A leased employee

A non-resident alien who received no U.S. earned income

A Board Member

Adjunct employees may not participate in the Medical and Dependent Care Flexible Spending Accounts

Classified by the Employer as non-benefiting temporary employees under its standard personnel policies and practices, uniformly and consistently applied

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan on the first day of the calendar month next following the date you first perform an hour of service as an Eligible Employee.

However, you will become a Participant eligible to make contributions and receive benefits from the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

Your ability to become a Participant in the Plan is subject to the following terms and conditions: For all Employees other than Adjunct: Qualified Employees are eligible to participate in the Plan as of first day of the month following your date of hire, unless your date of hire is the first work day of the month, in which case you are eligible to participate as of your date of hire. For Adjunct Employees (Adjunct employees may not participate in the

Medical or Dependent Care Flexible Spending Accounts): Adjunct faculty members deemed eligible per terms of the LRCFT Collective Bargaining Contract. The following enrollment requirements must be met: Must qualify as a member of the certificated employee unit (LRCFT), have taught two of the last five semesters (summer sessions not included) and have a Tentative Class Schedule (TCS) for the current semester. Must complete all of the enrollment procedures described in the LRCFT contract. Must be working on September 1 or March 1 of each academic year based upon an approved and processed Tentative Class Schedule providing for a total of at least 30% of full time (.300 FTE) or 4.5 formula hours. Workload assignments of other types (i.e. Employment Service Agreements, Personal Service Agreements, etc.) do not create FTE for medical and dental benefits. Adjunct employees must also certify on form #114 at the time of initial enrollment that they do not have other medical coverage. If they are a participant in a District insurance plan and become covered by another plan as an employee, spouse or dependent and that coverage is either fully paid or partially paid by another employer, they shall immediately become ineligible under the District plan and must notify the Employee Benefits Department within 30 days if such coverage exists.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

ELECTIONS

In General

When you become eligible to participate in the Plan, you may begin contributing to the Plan. Contributions pertaining to an account will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

When you are first eligible to participate in the Plan, you must return a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you have not returned an election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the FMLA

If you have a change in status, you may modify an election in your Health Care Reimbursement Account but your new annual contribution amount may not be less than the amount previously reimbursed at the time of the election change.

You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

HSA Special Rules. You may modify your election to make contributions to a health savings account ("HSA") at any time as long as the change is effective prospectively (i.e., after the request for the change is received). The Plan Administrator may place additional restrictions on the election of HSA contributions.

BENEFITS

Premium Conversion Account

When you become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

Employer Group Medical

Employer Dental

Employer Vision

If a contract is offered in conjunction with a Company-sponsored benefit plan, you will be eligible to make contributions to the Premium Conversion Account only if you are also eligible to participate in the applicable Company-sponsored plan, as described above and you are eligible to participate in this Plan.

In the event of a conflict between the terms of this Plan and the terms of a contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Care Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a Health Care Reimbursement Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the calendar year. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available for reimbursement. The maximum amount you may contribute each year is the maximum amount permitted (\$2,700 for 2019).

Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Care Reimbursement Account. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Health Savings Accounts

In addition, the Plan allows you to make pre-tax contributions to an HSA.

Dependent Care Assistance Account

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Assistance Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is \$5,000 (\$2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

You generally must file a Form 2441 to determine whether any part of your Dependent Care Assistance Account is taxable. Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

COMPANY CONTRIBUTIONS

Amount

The Company **may** make a contribution to help fund one or more of your accounts. The method used to determine the contribution and the method used to allocate the contribution is as follows: details and amounts associated will be announced annually during the Open Enrollment period.

Election to Receive Cash

You may make an election to have the Company contribution described above be paid to you rather than having the contribution credited to your account. The election is subject to the following terms and conditions: details and amounts associated will be announced annually during the Open Enrollment period. Any election to receive the contribution paid in cash must be returned to the Plan Administrator by the date specified on the form.

FORFEITURES

Plan Year/Termination

Except as provided below, any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, except as described below for dependent care expenses, any balance remaining in your account on the date you terminate employment with the Company will be forfeited after all claims are paid.

Effective January 1, 2010, if you cease to be participant in the cafeteria plan (because of termination of employment or other reason) you may continue to be reimbursed for eligible dependent care expenses through the end of the Plan Year (or grace period if applicable).

Grace Period

However, the unused balance in your account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year.

CLAIMS

Deadlines

You must submit claims for reimbursement by March 31. However, if you terminate employment you must submit claims (other than eligible dependent care expenses) for reimbursement within 90 days after your date of termination.

However, the unused balance in your account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year. You must submit claims incurred during the grace period for reimbursement by March 31.

Debit/Credit Cards

The Company will provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your Health Care Reimbursement Account and/or your Dependent Care Assistance Account. The Plan Administrator may provide you with more information about stored value cards at the time you enroll in the Plan. The following restrictions apply to the use of such card: Two debit cards will be provided to each Health Care Reimbursement Account (Health FSA) participant at no cost. Participants may be permitted to order a third or replacement debit card. A nominal fee may be deducted from the participant's Reimbursement Account balance when a third debit card is ordered, and/or when a new debit card is ordered to replace a lost or stolen card (refer to your enrollment materials for details about these charges). Any time the debit card is used, the administrator may require the participant to provide documentation to support the purchase. Should the participant not provide the required documentation in a timely manner, the claim will be denied and the participant will be required to repay the expense or, alternatively, the participant may choose to offset the expense with new expenses. Should the participant not repay the expense in a timely manner, the debit card may be suspended without further notification. In general, supporting documentation will be required for all debit card transactions with the exception of the following: (1) OTC medical supplies purchased at a retailer or pharmacy; (2) health plan co-payments; and, (3) recurring (ongoing) charges. The administrator will notify the participant whenever documentation is required. The debit card cannot be used to pay for day care expenses under the Dependent Care Assistance Account or individually owned health insurance through the Premium Reimbursement Account (if provided)..

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to BASIC pacific, Claims Processing at P.O. Box 2170, Rocklin, CA 95677. The telephone number is 800-574-5448; Fax 800-584-4591.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for

any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, and (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that, if possible, is conducted by an appropriate representative of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate Plan representative will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant will lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, and (3) a statement that the 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 Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits.

You may elect to continue coverage on a pre-tax or after tax basis for non medical benefits when on leave of absence under the FMLA.

Non FMLA Leave

In addition, you may elect to continue coverage on a pre-tax or after tax basis when on leave of absence **other** than the FMLA.

YOUR RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections. You have the right to:

Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition, the people who operate the Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under the Plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done.

If you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order or national medical support notice, you may file suit in Federal and/or state court.

If you have any questions about the Plan, you should contact the Plan Administrator.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor is Los Rios Community College District.

Its address is 1919 Spanos Court, Sacramento, CA 95825.

Its telephone number is 916-568-3070.

Its Employer Identification Number is 94-1576340.

The Plan Administrator is a committee appointed by Plan Sponsor. If no committee has been designated, the Plan Administrator will be the Plan Sponsor.

Its address and telephone number is that of the Plan Sponsor listed above.

2. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code and, to the extent the Plan provides for Health Care Reimbursement Account benefits, the Plan is also a welfare benefit plan. The Plan number is N/A.
3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.
4. The Company's fiscal year ends on 06/30 and the plan year ends on December 31.

Addendum

SUPPLEMENTAL INFORMATION PERTAINING TO THE SECTION TITLED "METHOD AND TIMING OF PAYMENT" UNDER "CLAIMS":

This section refers to traditional claims filed with the administrator using a claim form or by using the online claims filing feature. This section does not pertain to claims paid using a debit card (if applicable). Approved claims will be paid twice weekly on Wednesday and Friday (excluding administrator holidays). The cut off for the administrator to receive a claim is noon (Pacific Time Zone) on the previous day. For instance, claims received by the administrator prior to noon on Tuesday will be paid (if approved) on Wednesday. Currently, there is no minimum reimbursement amount imposed by the administrator. All claims submitted will be paid in accordance with this schedule (if otherwise approved), regardless of the amount requested. However, the administrator may choose to impose a minimum reimbursement amount in the future. Should a minimum reimbursement amount be imposed, it will be communicated to participants during the enrollment period that proceeds each new plan year. Currently, the administrator will not pay reimbursements directly to the service provider. Reimbursements may only be paid directly to the participant. In most cases, the participant may decide to receive reimbursements via check or direct deposit into their personal bank account (some plans limit reimbursements to direct deposit).

EFFECTIVE JANUARY 1, 2015: SUPPLEMENTAL INFORMATION PERTAINING TO THE SECTION TITLED "HEALTH CARE REIMBURSEMENT ACCOUNT" FOR PLANS THAT INCLUDE BOTH THE FULL HEALTH CARE REIMBURSEMENT ACCOUNT AND THE LIMITED PURPOSE HEALTH CARE REIMBURSEMENT ACCOUNT:

Some plans offer two distinct Health Care Reimbursement Accounts. The primary (or "full") Health Care Reimbursement Account reimburses participants for all their qualified medical expenses (including dental and vision) as defined under the Internal Revenue Code, with the exception of premiums for health insurance. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. The full Health Care Reimbursement Account is available to any eligible employee who does not contribute (either themselves or their spouse) to an HSA (Health Savings Account) during the same plan year. The alternative option is called a Limited Purpose Health Care Reimbursement Account. This second (or limited) account will only reimburse expenses incurred for qualified dental (including orthodontic) and vision services. The Limited Purpose Health Reimbursement Account will not reimburse any expenses other than those pertaining to dental and vision services (this includes expenses pertaining to accidents, disability, or preventive care). The Limited Purpose Health Care Reimbursement Account is available to any eligible employee who themselves (or their spouse) may contribute to an HSA during the same plan year. The reason why a participant might choose to enroll in the Limited Purpose Health Care Reimbursement Account while also contributing to an HSA is to avoid using their HSA funds to pay for dental and vision related expenses. Not all Plans include the Limited Purpose Health Care Reimbursement Account. Refer to your enrollment materials for details of what your Plan offers.

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;

Your spouse's hours of employment are reduced;

Your spouse's employment ends for any reason other than his or her gross misconduct;

Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; Death of the employee; The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Company at 1919 Spanos Court, Sacramento, CA 95825. The Company's telephone number is 916-568-3070.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as payment to maintain coverage for the remainder of that plan year's spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

The COBRA continuation coverage lasts only until the end of the plan year in which the qualifying event occurs. COBRA continuation coverage may only be elected under this plan if, as of the date of the qualifying event, the maximum benefit available under the plan for the remainder of the plan year is more than the maximum amount that the Plan could require as payment to maintain coverage for the remainder of that plan year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Jamie Ruggles, CPA - Director of Accounting Services
1919 Spanos Court
Sacramento, CA 95825
[916-568-3069](tel:9165683069)

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