RESOLUTION NO. 2014-149

A RESOLUTION OF THE CITY COUNCIL OF ROHNERT PARK AUTHORIZING AND APPROVING (1) ADMINISTRATIVE SERVICES AGREEMENT – FLEXIBLE BENEFITS, (2) MUTUAL BUSINESS ASSOCIATE AGREEMENT AND (3) A CITY OF ROHNERT PARK FLEXIBLE BENEFITS PLAN WITH HEALTHCOMP, A THIRD PARTY ADMINISTRATOR, TO ADMINISTER HEALTH FLEXIBLE SPENDING ACCOUNTS AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

WHEREAS, the City of Rohnert Park desires to offer its employees the opportunity to participate in pre-tax contributions to Health Flexible Spending Accounts ("Health FSA") and Dependent Care Flexible Spending Accounts ("Dependent Care FSA"); and

WHEREAS, the City of Rohnert Park 2014 Flexible Benefits Plan establish with AFLAC and approved on October 28, 2014 pursuant to Resolution 2014-132 is administered on a fiscal plan year and the City's Health and Dependent Care FSAs are the only two pre-tax benefits administered on a calendar plan year, it is necessary to establish the "City of Rohnert Park Flexible Benefits Plan" to comply with legal requirements for plan year benefit administration; and

WHEREAS, HealthComp, a third party benefit administrator, is in the business of providing administrative services in conjunction with such Plans, and the City as Plan Sponsor desires to engage HealthComp to perform the services enumerated in an Administrative Services Agreement – Flexible Benefits; and

WHEREAS, the City and HealthComp in the performance of their contractual obligations to each other, or to other third parties, may exchange Protected Health Information ("PHI") and desire to enter into a Mutual Business Associate Agreement to accurately reflect the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as they apply to the disclosure and breach of PHI.

NOW, THEREFORE, BE IT RESOLVED that the City Council of the City of Rohnert Park hereby approves (1) The City of Rohnert Park Flexible Benefits Plan which is attached hereto as Exhibit A and is incorporated herein by this reference; (2) the Administrative Services Agreement – Flexible Benefits which is attached hereto as Exhibit B and is incorporated herein by this reference and (3) Mutual Business Associate Agreement which is attached hereto as Exhibit C and is incorporated herein by this reference.

BE IT FURTHER RESOLVED that the City Manager is authorized and directed to execute the City of Rohnert Park Flexible Benefits Plan, Administrative Services Agreement, Mutual Business Associate Agreement and any other necessary documents on behalf of the City of Rohnert Park.

DULY AND REGULARLY ADOPTED by the City Council of the City of Rohnert Park this 10th day of November, 2014.

CITY OF ROHNERT PARK

Joseph T. Callinan, Mayor

ATTEST:

JoAnne Buergler, City Clerk

Attachments: Exhibits A, B, and C

BELFORTE: Aye **MACKENZIE:** Aye **STAFFORD:** Aye **AHANOTU:** Aye **CALLINAN:** Aye

AYES: (5) **NOES:** (0) **ABSENT:** (0) **ABSTAIN:** (0)

EXHIBIT A

CITY OF ROHNERT PARK FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

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SUMMARY

CITY OF ROHNERT PARK FLEXIBLE BENEFITS PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan as of your date of hire with us. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan,

you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make

corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV
BENEFITS

1. What benefits are offered under the Plan?

Under our Plan, you can pay for the following benefits or expenses during the year:

2. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is $2500. After 2014, the dollar limit may increase for cost of living adjustments. The minimum amount that you may contribute to the Health Flexible Spending Account each Plan Year is $200. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to $500. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

3. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

4. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

-- Health care premiums under our insured group medical plan.

-- Dental insurance premiums.

-- Vision insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are

generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses incurred during the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

(c) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

7. Qualified Reservist Distributions

If you are a member of a reserve unit and if you are ordered or called to active duty, then you may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in your Health Flexible Spending Account. You can only request this distribution if you are called to active duty for a period of 180 days or more or for an

indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the call.

You can receive the amount you have actually contributed minus any reimbursements you have already received (or are in process). The amount you request may be adjusted if needed to conform with your actual account balance. You must request the QRD before the last day of the Plan Year. You can only request one QRDs for a Plan Year.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

City of Rohnert Park Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your amended Plan become effective on January 1, 2015. Your Plan was originally effective on July 14, 1987.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on July 1 and ends on June 30, except for the short Plan Year which will begin on January 1 and end on June 30.

2. Employer Information

Your Employer's name, address, and identification number are:

City of Rohnert Park
130 Avram Avenue
Rohnert Park, California 94928
94-1538585

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

City of Rohnert Park
130 Avram Avenue
Rohnert Park, California 94928
707 585-6730

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

City of Rohnert Park
130 Avram Avenue
Rohnert Park, California 94928

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

HealthComp Administrators
P.O. Box 45018
Fresno, CA 93718-5018

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care or medical expense claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage

is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required

periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a part of the premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the 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 or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed

or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

City of Rohnert Park
130 Avram Avenue
Rohnert Park, California 94928

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension. Once

the Plan Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(e) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of

COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of 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 or its designee.

XI
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

EXHIBIT B

HealthComp®
Third Party Administrators

ADMINISTRATIVE SERVICES AGREEMENT – FLEXIBLE BENEFITS

This Administrative Services Agreement – Flexible Benefits (Agreement) is made by and between, **City of Rohnert Park** ("Plan Sponsor"), whose principal address is **130 Avram Avenue, Rohnert Park, California 94928** and HealthComp, a California Corporation dba HealthComp Administrators ("HealthComp"), whose principal address is 621 Santa Fe Avenue, Fresno, California, 93721 with respect to the Flexible Benefit Plan issued by the Plan Sponsor. This Agreement is to be in effect as of **November 1, 2014** (Effective Date) and shall continue until terminated as herein provided.

WHEREAS, the Plan Sponsor has established a Flexible Benefit Plan pursuant to the Internal Revenue Code Section 125 as amended, (the "Plan") for eligible employees of the Plan Sponsor (the "Participants"); and

WHEREAS, HealthComp is in the business of providing administrative services in conjunction with such Plans, and Plan Sponsor desires to engage HealthComp to perform the services enumerated herein below:

NOW, THEREFORE, in consideration of the premises and of the mutual promises and covenants contained therein, the parties agree as follows:

I. PLAN

1.1 **Plan Document.** Plan Sponsor understands that ERISA requires that its employee welfare benefit plan be established and be maintained pursuant to a written instrument(s), including a Plan Document. All services to be provided by HealthComp hereunder shall be performed pursuant to the provisions of the Plan Document, as amended by Plan Sponsor. A copy of the Plan Document and any amendments thereto shall be deemed to form part of this Agreement for such purpose.

Plan Sponsor shall provide HealthComp with the Plan Document at least thirty (30) days prior to the Effective Date of this Agreement or such other date as may be mutually agreed upon by the parties in writing. Plan Sponsor shall notify HealthComp in writing of any changes to the Plan Document or Plan benefits at least thirty (30) days prior to the effective date of such changes. HealthComp shall have thirty (30) days following receipt of the Plan Document or such notice to inform Plan Sponsor of whether it will administer the Plan Document or such proposed changes, HealthComp's decision not being unreasonably withheld, conditioned or delayed.

1.2 **Interpretation of the Plan.** Plan Sponsor shall be the final arbiter as to the interpretations of the Plan and as to the payment of benefits thereunder. HealthComp shall consult with Plan Sponsor in the event extraordinary benefit matters arise. In the event an exception is to be made, Plan Sponsor will notify HealthComp in writing of such exception.

II. SCOPE OF RELATIONSHIP

2.1 **Parties**. This Agreement is between HealthComp and the Plan Sponsor, and does not create any rights or legal relationships between HealthComp and any of the Participants or beneficiaries under the Plan, or to any other third party. In the event that the Plan Sponsor fails to comply with any federal or state law, required filings, or the terms of the Plan, HealthComp shall not be liable in any action brought with such regard. HealthComp's relationship with the Plan Sponsor shall be that of an independent contractor, and nothing in this Agreement shall be construed as creating the relationship of City of Rohnert Park and employee, partnership or joint venture between the parties. Plan Sponsor also acknowledges that HealthComp shall not be deemed a party to any contract entered into on behalf of Plan Sponsor for any purpose intended primarily to benefit the Plan, and Plan Sponsor assumes all contractual and financial obligations related thereto.

2.2 **Fiduciary**. HealthComp shall not be deemed to be a fiduciary of the Plan, nor shall HealthComp be considered to be the "Plan Administrator" for purpose of ERISA or any other proposes. Rather, the duties of HealthComp hereunder are ministerial in nature, and this Agreement shall not be deemed to confer or delegate to HealthComp any discretionary authority or discretionary responsibility in the administration of the Plan. Rather, HealthComp shall exercise its obligations under the Agreement in accordance with and by applying industry accepted, or commonly accepted, standards and practices regarding the common interpretation, definition, and application of the Plan Document provisions.

2.3 **Communications**. HealthComp shall be entitled to rely, without question, upon any written or oral communication from the Plan Sponsor, including, but not limited to, its directors, officers, human resource and benefit personnel, other authorized employees and its appointed agents/brokers.

Any written notice required by this Agreement shall be delivered personally or sent by Registered Mail, return receipt requested, to the persons and at the addresses listed herein, unless a party designates a different address in writing:

HealthComp 621 Santa Fe Fresno, CA 93721 Attn: Phil Musson President & CEO	City of Rohnert Park 130 Avram Avenue Rohnert Park, CA 94927 Attn: Victoria Perrault Director of Human Resources

2.4 **Plan Sponsor's Representatives**. Plan Sponsor, wherever referenced in the Agreement, includes its directors, officers, employees, agents/brokers and others retained to or acting on Plan Sponsors behalf.

2.5 **HealthComp's Representatives**. HealthComp, wherever referenced in the Agreement, includes its directors, officers, employees, agents and others retained to or acting on HealthComp's behalf.

III. DUTIES OF HEALTHCOMP

3.1 **Documentation**. At the request of Plan Sponsor, HealthComp may review, update or prepare a proposed Plan Document or proposed Plan Document Amendments describing the benefits of the Plan pursuant to Exhibit A. Plan Sponsor understands its responsibility to review, approve and execute the Plan Document and Plan Document Amendments. Plan Sponsor agrees that HealthComp

shall have no responsibility with respect to the validity of the Plan Document and Plan Document Amendments.

3.2 **Standard Administrative Services.** HealthComp agrees to provide the below-numerated services for the Plan:

a) Provide standard enrollment materials;

b) Prepare weekly reimbursement checks for the amount of benefits determined to be payable under the Plan;

c) Provide Participants with online access to their own account(s) through Flex OnLine including mobile app;

d) Provide Plan Sponsor monthly list billings and analysis reports;

e) Correspond with the Participants if additional information is deemed necessary by HealthComp to complete the processing of claims;

f) Provide a toll-free 800 Customer Service telephone number to Participants;

g) Facilitate direct deposit to Participant's account from Plan Sponsor's account;

h) Facilitate automatic electronic claim transfers when HealthComp administers health plan;

i) Provide annual Participant statements; and

j) Posting of annual health care spending account elections.

3.3 **Records and Files.** HealthComp shall establish and maintain a record keeping system concerning the services to be performed hereunder. All such records, including an accumulator report and member eligibility listing of such, and all hard copy files shall be the property of Plan Sponsor and shall be delivered to Plan Sponsor upon termination of the Agreement, subject to the right of HealthComp to copy and retain all or any of such records as it may be required by law to retain. All such records shall be available for inspection by Plan Sponsor upon reasonable prior written notice, and at any time during HealthComp's normal business hours.

3.4 **Practices and Procedures.** In performing such services, HealthComp shall employ its standard practices and procedures, whether written or otherwise provided, however, such performance shall be subject to the provisions of this Agreement, including, but not limited to Section 1.2.

3.5 **Annual Form 5500.** At the request of Plan Sponsor pursuant to Exhibit A, HealthComp shall prepare for Plan Sponsor's review the annual form 5500. The approval and filing of the annual form 5500 shall remain the responsibility of Plan Sponsor.

3.6 **Confidentiality of Personal Information**. HealthComp maintains a Privacy Policy. HealthComp shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the Plan, except in the following instances:

a) In response to a court order;

b) For an examination conducted by the Commissioner of Insurance;

c) For an audit or investigation conducted under the ERISA or by any authorized governmental department with jurisdiction;

d) To, or at the request of, Plan Sponsor; or

e) With the written consent of the individual identified by the information, or his or her legal representative.

Nothing in this section is to be inconsistent with any Business Associate Agreement executed by and between Plan Sponsor and HealthComp.

3.7 **Recovery of Payment.** The parties will cooperate to make reasonable efforts to recover overpayments of benefits under the Plan. In the event payment is made to or on behalf of an ineligible employee, Participant or any ineligible dependent of an employee Participant or a payment is made in excess of the amount properly payable, HealthComp will:

a) Promptly advise in writing the Plan Sponsor of such event; and

b) Make a minimum of three demands to the payee in writing for the return of such payment or overpayment and report the result of such efforts to the Plan Sponsor.

HealthComp shall have no further obligation with respect to any such payment or overpayment, except that HealthComp is hereby authorized to offset such payment or overpayment against any unpaid claim of such payee or any dependent thereof unless advised otherwise by the Plan Sponsor. HealthComp in its sole discretion may choose to use additional reasonable methods in an attempt to recover such payment or overpayment.

IV. DUTIES OF PLAN SPONSOR

4.1 **Account.** Plan Sponsor shall establish, maintain and timely fund a checking account ("Account") for the payment of benefits under the Plan. Plan Sponsor shall be liable for all claim checks issued against the Account. HealthComp shall provide Plan Sponsor monthly with a report for reconciliation.

4.2 **Service Fees.** Plan Sponsor agrees to pay to HealthComp the Service Fees as set forth in Exhibit A in advance and not later than thirty (30) days following the date of HealthComp's statement for Services Fees.

4.2.1 **Change of Service Fees.** HealthComp reserves the right to change the Service Fees applicable to the Agreement at any time, provided the then-current Service Fees have been applicable for a period of twelve (12) months, and provided that written notice of such change is furnished to the Plan Sponsor at least thirty (30) days prior to the effective date for the new Service Fees.

4.2.2 **Audit Fees.** HealthComp recognizes that from time to time Plan Sponsor may wish to perform (or have performed) an audit for purposes of financial statements, performance standards, claims payment, or other purposes. Plan Sponsor shall provide reasonable written notice to HealthComp prior to such audits, and HealthComp shall make all requested information available to Plan Sponsor or their designated auditor within a reasonable time frame, but in no instance less than fifteen (15) business days from receipt of notice of the audit. Plan Sponsor agrees to pay HealthComp the hourly Administrative Service Fee shown in Exhibit A for any HealthComp staff time required by such an audit and any other

costs incurred by HealthComp within thirty (30) days following the date of HealthComp's statement for the hourly Administrative Service Fee and incurred costs. Plan Sponsor also agrees that HealthComp will have the right to submit written responses to any audit findings, and that such written responses will be included in any audit report which is prepared.

4.3 **Liability for Benefits.** It is understood and agreed that liability for payment of benefits under the Plan is the sole liability of Plan Sponsor, and that HealthComp shall not have any liability for such benefits. Plan Sponsor shall be responsible for any damages, losses, liabilities, or expenses incurred by HealthComp which are related to claims by any employee, Participant, dependent of employee Participant or a provider of health care services for benefits under the Plan. Both parties recognize that this includes claims or liabilities to which either Party is determined to be obligated either contractually or statutorily, regardless if such claims are allowed under the Plan Document.

4.4 **Taxes, Assessments and Liability.** It is understood and agreed that nothing in this Agreement will be deemed to confer on HealthComp any obligation, responsibility or liability for any tax (exclusive of HealthComp's Federal or State income and payroll taxes), assessment, levy, fee, subsidy or charge which may be imposed upon Plan Sponsor, Trust, Administrator, Fiduciary or any Participant or beneficiary of the Plan.

It is understood and agreed Plan Sponsor will reimburse HealthComp within thirty (30) days after HealthComp's notice to Plan Sponsor for all amounts HealthComp pays for any tax, assessment, levy, fee, subsidy or charge imposed by any public body or governmental authority against HealthComp, the Plan or Plan Sponsor (exclusive of HealthComp's Federal or State income and payroll taxes) which may be incurred by reason of or as a result of the existence of the Plan, this Agreement or HealthComp's services pursuant to this Agreement.

4.5 **Plan Sponsor Responsibilities.** The Plan Sponsor agrees to:

a. Determine the eligibility of employees to participate in the Plan;

b. Provide HealthComp with completed enrollment forms and reports necessary to properly administer the Plan;

c. Remit in a timely manner Participant's salary reductions and fees;

d. Furnish HealthComp such information in writing as may be necessary or required by HealthComp from time to time to maintain adequate records for eligibility of Plan Sponsor's Participants;

e. Immediately provide HealthComp with such information regarding administration of the Plan as HealthComp may request from time to time. HealthComp is entitled to rely on the information most recently supplied by Plan Sponsor in connection with HealthComp's services and its other obligations under the Agreement. HealthComp shall not be responsible for any delay or error caused by Plan Sponsor's failure to furnish correct information in a timely manner; and

f. Take all other actions necessary to maintain and operate the Plan in compliance with applicable provisions of the Plan, the Internal Revenue Code, and any other applicable state and/or federal law. Unless otherwise agreed to in writing between HealthComp and Plan Sponsor, Plan Sponsor agrees that it is solely responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law.

V. GENERAL PROVISIONS

5.1 **Entire Contract.** This Agreement, together with any Exhibits, Attachments and Amendments hereto, constitutes the entire Agreement between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. No representation, understanding, or agreement which is not expressly contained herein shall be binding or enforceable. No modification of the terms or provisions of the Agreement shall be effective unless evidenced by writing signed by an authorized officer of both Plan Sponsor and HealthComp.

5.2 **Choice of Law and Attorney's Fees.** This Agreement shall be deemed to have been made and entered into in the State of California, and shall be construed and enforced according to the internal laws of the State of California, applicable to contracts entered into and performed solely within that state. In the event suit is brought to enforce or interpret any part of this contract, the prevailing party shall be entitled to recover reasonable attorney's fees as an element of their costs of suit. The "prevailing party" shall be the party who is entitled to recover costs of suit, whether or not the suit ends with a final judgment.

5.3 **Fair Reading and Joint Construction.** The Agreement is a result of negotiations between the parties, and will not be construed strictly against or in favor of any party hereto, but shall be considered to have been jointly drafted by the parties. The parties intend that the Agreement will be given a fair reading and reasonable construction in accordance with the intentions of the parties and without regard to, or aid of, §1654 of the California Civil Code.

5.4 **Section Headings.** The paragraph, section and article headings used in the Agreement are intended solely for convenience and reference and shall not in any manner amend, limit, modify or otherwise be used in the interpretation of any of the provisions of the Agreement.

5.5 **No Waiver.** No waiver of any breach of any term or provision of the Agreement shall be construed to be, or shall be, a waiver of any other breach of the Agreement. No waiver shall be binding unless in writing and signed by the Party or Parties waiving the breach.

5.6 **Severability**. If any term or provision of the Agreement is determined to be illegal, unenforceable, or invalid in whole or in part for any reason, such illegal, unenforceable, or invalid provision or part thereof shall be stricken from this Agreement and such provision shall not affect the legality, enforceability, or validity of the remainder of this Agreement. If any provision or part thereof of the Agreement is stricken in accordance with the provisions of this section, then this stricken provision shall be replaced, to the extent possible, with a legal, enforceable, and valid provision that is as similar in tenor to the stricken provision as is legally possible.

5.7 **Warranty of Authority.** The parties signing below warrant they are authorized to enter into this Agreement on behalf of their designated party, and do so with that party's full consent and knowledge.

5.8 **Indemnification of Plan Sponsor.** In the event of any claim or cause of action against Plan Sponsor, HealthComp agrees to indemnify Plan Sponsor and hold it harmless from and against any and all resultant liabilities, damages and expenses incurred by Plan Sponsor, including court costs and attorneys' fees, to the extent that the liabilities, damages or expenses arise as a result of the negligence of HealthComp or HealthComp's intentional, willful, reckless or grossly negligent acts or omissions in the performance of its duties under this Agreement.

5.9 **Indemnification of HealthComp.** In the event of any claim or cause of action against HealthComp by any employee, Participant, dependent of employee Participant or health care provider claiming benefits or right to payment under the Plan, Plan Sponsor agrees to indemnify HealthComp and hold it harmless from and against any and all resultant liabilities, damages and expenses incurred by HealthComp, including court costs and attorneys' fees, to the extent that liabilities, damages or expenses arise other than as a result of the negligence of HealthComp or HealthComp's reckless acts or omissions in the performance of its duties under this Agreement. Provided further, nothing in this Section or any other provision of this Agreement shall entitle HealthComp to be indemnified, reimbursed, or held harmless for any negligent or wrongful acts or omissions of HealthComp, its employees, officers, directors, affiliates, or subcontractors.

VI. TERM OF AGREEMENT

6.1 **Term.** This Agreement shall commence on the Effective Date and shall remain effective unless terminated as provided herein.

6.2 **Termination by Notice.** Either party may terminate this Agreement for any reason at any time by providing written notice to the other party. The notice shall specify an effective date of termination, which shall be not less than sixty (60) days after the date of the notice. If the notice does not specify a date of termination, the effective date of termination shall be sixty (60) days after receipt of the notice by the other party.

6.3 **Termination by Default.** Should either party default in the performance of any of the terms or conditions of the Agreement, the other party shall deliver (personally or by Registered Mail, return receipt requested) to the defaulting party written notice thereof specifying the matters in default. The defaulting party shall have ten (10) calendar days after its receipt of the written notice to cure such default. If the defaulting party fails to cure the default within such ten-day period, this Agreement shall terminate at 11:59 p.m. on the tenth day after the receipt of the notice by the defaulting party.

6.4 **Termination by Law.** If any state or federal law or regulation is enacted or promulgated which prohibits the performance of any of the duties hereunder, or if any law is interpreted by a court of competent jurisdiction or any governmental agency or instrumentality to prohibit such performance, this Agreement shall automatically terminate as of the effective date of such prohibition.

6.5 **Termination via Bankruptcy**. This Agreement shall automatically and immediately terminate if either party: (1) becomes insolvent, seeks bankruptcy protection, or is adjudicated as a bankrupt entity; (2) if their business or operations come into possession of or under the control of any trustee in bankruptcy; (3) a receiver is appointed for the party's business or operations; or (4) it makes a general assignment for the benefit of creditors. But this provision may be waived if the other party affirmatively elects in writing to waive said termination.

6.6 **Effect of Termination.** As of the effective date of termination of this Agreement, HealthComp shall have no further duties of performance hereunder. This period between notice of termination and the effective date of termination shall be used to facilitate an orderly transfer of records and funds, if any, from HealthComp to the Plan Sponsor or to such person as Plan Sponsor may designate in writing. Any record transfer shall be completed within fifteen (15) calendar days of the termination date. HealthComp's obligation under Section 5.8 and Plan Sponsor's obligation under Section 5.9 shall survive the termination of this Agreement.

CITY OF ROHNERT PARK

By: _____
(Signature)

_____
(Print or type name)

Title:_____

Date: _____

HEALTHCOMP

By: _____
(Signature)

_____
(Print or type name)

Title: _____

Date: _____

EXHIBIT A
FEE SCHEDULE

CITY OF ROHNERT PARK
EFFECTIVE: November 1, 2014

$1,000.00 Initial Plan Set-Up including Standard Plan Document and Summary Plan Description.

$ 250.00 Standard Plan Amendment.

$ 250.00 Annual Non Discrimination Testing.

$ 6.00 Flexible Spending Account Standard Administration and Retiree Health Reimbursement Account Per Participant per Month. No charge for Premium Only Plan. (The minimum monthly administration fee is $195.00).
Services include the following:

1. Provide standard enrollment materials;
2. Prepare weekly reimbursement checks for the amount of benefits determined to be payable under the plan;
3. Provide Participants with access to their own account(s) with Flex OnLine including mobile app;
4. Provide monthly list billings and monthly year-to-date analysis reports;
5. Correspond with the Participants if additional information is deemed necessary by HealthComp to complete the processing of claims;
6. Provide a toll-free 800 Customer Service telephone number to Participants;
7. Facilitate direct deposit to Participant's account from Plan Sponsor's account;
8. Facilitate automatic electronic claim transfers when HealthComp administers health plan;
9. Provide annual Participant statements; and
10. Posting of annual healthcare spending account elections.

$ 80.00 Per Hour Administrative Service Fee or for services not previously listed.

$ 0.50 Bank Account Reconciliation Per Participant per Month.

$ 0.50 COBRA for Flexible Spending Account Medical Spending Per Participant per Month.

Accept: _____ Decline: _____
Signature Signature

$ 2.00 Debit card Per Participant per Month ($10 card replacement).

$ 250.00 Per Plan – Annual Form 5500 preparation.

Accept: _____ Decline: _____
Signature Signature

CITY OF ROHNERT PARK

By:_____
(Signature)

_____
(Print or Type Name)

Title:_____

Date: _____

HEALTHCOMP

By:_____
(Signature)

_____
(Print or Type Name)

Title:_____

Date:_____

Per Resolution Number 2014-_____ adopted by City Council on November 10, 2014.

Approved as to form:

By:_____
Michelle Marchetta Kenyon
City Attorney

Attest

_____
City Clerk

EXHIBIT C

MUTUAL BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is made between The City of Rohnert Park, whose principal place of business is 130 Avram Avenue, Rohnert Park, California, 94928, and HealthComp, a California Corporation, whose principal address is 621 Santa Fe Avenue, Fresno, California, 93721. This Agreement is for the purpose of addressing the measures that the Parties will take to protect the confidentiality of certain health information that either Party may deliver to the other, or that one Party may receive on behalf of the other. This Agreement is to be in effect as of November 1, 2014 and shall continue until terminated as herein provided.

WHEREAS, the disclosure of certain health-related information is regulated by the provisions of 45 U.S.C. §§1171 et seq., enacted by (i) the *Health Insurance Portability and Accountability Act of 1996* and the regulations promulgated thereunder (collectively referred to as "HIPAA Implementing Regulations"); (ii) Title XIII of the *American Recovery and Reinvestment Act* of 2009 (ARRA) entitled *Health Information Technology for Economic and Clinical Health Act* ("HITECH") 42 U.S.C. §§17921, et seq.; and (*iii*) the requirements of the final modifications to the HIPPA Privacy, Security, Enforcement and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013, 75 Fed Reg 5566, ("the Final Regulations"). The Implementing Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Agreement as "the HIPAA Requirements".

WHEREAS, in performance of their contractual obligations to each other, or to other third parties, the Parties may exchange Protected Health Information ("PHI", as that term is defined by the HIPAA Requirements) in connection with health benefit plans for which HealthComp provides third party administration services;

WHEREAS, one Party may receive or disclose PHI on behalf of the other Party in connection with those contractual obligations;

WHEREAS, the Parties desire that this Agreement accurately reflect the requirements of the HIPAA Requirements as they apply to the disclosure and breach of PHI; and

WHEREAS, the Parties agree to incorporate into this Agreement any regulations issued by the U.S. Department of Health & Human Services ("DHHS") with respect to the HIPAA Requirements that relate to the obligations of either Party and that are required to be reflected in a Business Associate Agreement. The Parties recognize that they are obligated by law to meet the applicable HIPAA Requirements and that each Party has direct liability for any violation of the HIPAA Requirements.

NOW, THEREFORE, the Parties agree as follows:

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Requirements: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information

("PHI"), Electronic Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean both Parties, individually and jointly.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean both Parties, individually and jointly.

(c) HIPAA Requirements. "HIPAA Requirements" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Parties

Parties agree to:

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

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;

(c) Report to the other Party any known use or disclosure of PHI not permitted under the Agreement, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors or service suppliers that create, receive, maintain, or transmit PHI on behalf of the Party agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information and execute a written Business Associate Agreement reflecting same;

(e) Make PHI available in a designated record set to the other Party or to the "individual or the individual's designee" as necessary to satisfy either Party's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to PHI in a designated record set as directed or agreed to by the other Party pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the other Party's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the other Party or "individual" as necessary to satisfy either Party's obligations under 45 CFR 164.528; and

(h) To the extent either Party is to carry out one or more of the other Party's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the other Party in the performance of such obligation(s).

Permitted Uses and Disclosures by Business Associate

(a) Each Party may use or disclose PHI only for any lawful purpose and as required for the performance of that Party's obligations under any contract or agreement related the administration of or providing of services to, a health care plan, and only if the disclosure is in compliance with the HIPAA Requirements.

Except as otherwise limited in this Agreement, the Parties may disclose PHI to either Party's other Business Associates or vendor of personal health records, provided that such use or disclosure would not violate any Privacy Rule and that the other entity has executed a written Business Associate Agreement with the Party.

(b) The Parties may use or disclose PHI as required by law.

(c) The Parties agree to make uses and disclosures and requests for PHI consistent with the other Party's minimum necessary policies and procedures.

(d) Neither Party may use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the other Party.

(e) Either Party may use PHI for the proper management and administration of that Party or to carry out the legal responsibilities of that Party.

(f) Each Party may disclose PHI for the proper management and administration of that Party or to carry out the legal responsibilities of that Party, provided the disclosures are required by law, or the Party obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Party of any instances of which it is aware in which the confidentiality of the information has been breached.

Provisions for Party to Inform Other Party of Privacy Practices and Restrictions

(a) Each Party shall notify the other Party of any limitation(s) in the notice of privacy practices of that Party under 45 CFR 164.520, to the extent that such limitation may affect the other Party's use or disclosure of PHI.

(b) Each Party shall notify the other Party of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect that Party's use or disclosure of PHI.

(c) Each Party shall notify the other Party of any restriction on the use or disclosure of PHI that the Party has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect the Party's use or disclosure of PHI.

Permissible Requests by Parties

Neither Party shall request the other Party to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 (or any other HIPAA Requirements) if done by covered entity.

Investigations

The Parties shall make their internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the United States Department of Health and Human Services (the "Secretary") for purposes of determining the Parties' compliance with applicable law. A Party shall immediately notify the other Party in the event they receive or are otherwise notified of any request by the Secretary to conduct an investigation of the use or disclosure of PHI.

Audit Rights

A. **Right to Audit.** Either Party, or its representative, shall be entitled after ten (10) business days' prior written notice to the other Party, to audit that Party to verify their compliance with the terms of this Agreement. The auditing Party shall be entitled and enabled to inspect the records and other information relevant to the audited Party's compliance with the terms of this Agreement. The auditing Party shall conduct its review during the normal business hours of the audited Party, and shall have the right to conduct the audit in any reasonable manner which does not unreasonably interfere with the audited Party's normal operations.

B. **Obligation to Maintain Records.** The Parties shall produce and maintain accurate and complete records of all receipts, transmissions, uses, and disclosures of PHI subject to HIPAA and HITECH reporting standards, throughout the term of any contracts between the Parties, or for such longer period as may be Required By Law. The Parties shall maintain all records and other information in a safe and secure environment and in compliance with applicable laws. The Parties shall maintain all records and other information with a system of audit trails and controls sufficient to allow either Party to confirm the other Party's compliance with any requirements or regulations enforced by the Secretary.

Term and Termination

(a) Term. The Term of this Agreement shall terminate when all PHI exchanged between the Parties, or received by one Party on behalf of the other Party, is destroyed. Or, if it is not reasonably feasible to destroy the PHI, all protections created by this Agreement shall be extended to that PHI, or the date either Party terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Either Party may terminate this Agreement if that Party determines that the other Party has violated a material term of the Agreement

(c) Obligations of Parties Upon Termination. Upon termination of this Agreement for any reason, each Party shall return to the other Party all PHI received from that Party, or created, maintained, or received by the Party on behalf of the other Party that the Party still maintains in any form. The Party shall retain no copies of the PHI.

Upon termination of this Agreement for any reason, each Party, with respect to PHI received from the other Party, or created, maintained, or received by the Party on behalf of the other Party, shall:

1. Retain only that PHI which is necessary for the Party to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to the other Party the remaining PHI that the Party still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Party retains the PHI;
4. Not use or disclose the PHI retained by the Party other than for the purposes for which such PHI was retained and subject to the same conditions which applied prior to termination; and
5. Return to the other Party the PHI retained by the Party when it is no longer needed by the Party for proper management and administration or to carry out its legal responsibilities.

(d) Survival. The obligations of both Parties under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Requirements means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement as is necessary to allow the Parties to meet their contractual obligations to comply with the requirements of the Privacy Rule or any other HIPAA Requirement. In the event of any amendment to HIPAA or HITECH or any other Privacy-related Rule, this Agreement will be deemed by all Parties to concurrently adopt such amendments and incorporate them in this Agreement as necessary to comply with such regulation or amendment. Such modifications to this Agreement will immediately be effective without the necessity of a signed amendment.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Requirements.

Indemnification

In the event a Party negligently allows the improper or unauthorized use, disclosure or breach of PHI, that Party agrees to defend and indemnify the other Party and hold it harmless from and against any and all claims, causes of action, losses, liabilities, damages and expenses, including court cost and attorneys' fees, to the extent that such claims, causes of action, losses, liabilities, damages and expenses which arise from such improper or unauthorized use or disclosure.

Obligations of Party's Subcontractors, Vendors and Other Third Parties

The Parties agree that as required by the HIPAA Requirements, each Party will enter into written Business Associate Agreements with all other Business Associates, or vendors or other third parties with access to PHI, that requires them to comply with Privacy and Security Rule provisions of this Agreement in the same manner as required of Parties, and notifies that Business Associate that they will incur liability under the HIPAA Requirements for non-compliance with such provisions. The Parties will assure that all other Business Associates provide written agreement to the same privacy and security restrictions, conditions and requirements that apply to the Parties regarding PHI.

Warranty of Authority

The Parties signing below warrant they are authorized to enter into this Agreement on behalf of their designated Party, and do so with that Party's full consent and knowledge.

CITY OF ROHNERT PARK

By:_____

(Signature)

_____

(Print or type name)

Title:_____

Date:_____

HEALTHCOMP

By:_____

(Signature)

_____

(Print or type name)

Title:_____

Date:_____

Per Resolution Number 2014-_____ adopted by City Council on November 10, 2014.

Approved as to form:

By:_____
Michelle Marchetta Kenyon
City Attorney

Attest

_____
City Clerk