

CITY OF STOCKTON



**REQUEST FOR SEALED BIDS
TO PROVIDE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
ADMINISTRATION SERVICES
FOR THE CITY OF STOCKTON, CALIFORNIA
(PUR 16-013)**

**BIDS WILL BE RECEIVED UNTIL THE HOUR OF
2:00 O'CLOCK P.M., THURSDAY, OCTOBER 13, 2016,
IN THE OFFICE OF THE CITY CLERK,
FIRST FLOOR, CITY HALL, 425 NORTH EL DORADO STREET,
STOCKTON, CALIFORNIA 95202-1997**

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NOTICE INVITING SEALED BIDS

NOTICE IS HEREBY GIVEN that sealed bids are invited by the City of Stockton, California to provide **HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATION SERVICES (HRA) (PUR 16-013)** in strict accordance with the specifications.

The City is seeking bids from firms to provide third party administration (“TPA”) services for the newly implemented Health Reimbursement Arrangement (“HRA”) plan for the City of Stockton’s Fire, Fire Management, and Operations and Maintenance Units, and all future bargaining units that adopt the model plan.

The bid specifications and forms can be obtained from the City of Stockton’s website at www.stocktongov.com/bidflash and must be delivered to the Office of the City Clerk, City Hall, 425 North El Dorado Street, Stockton, California, up to but no later than **2:00 p.m., on THURSDAY, OCTOBER 13, 2016.**

The City reserves the right to reject any and/or all bids received.

For Information on Technical Data or Bid Process/Clarification, contact:

Tami Matuska, HUMAN RESOURCES
Concepcion Gayotin, PURCHASING
Tom Morrison, SEGAL

via email - Purchasing@stocktonca.gov

DISCLAIMER: The City does not assume any liability of responsibility for errors/omissions in any document transmitted electronically.

Dated: September 22, 2016

BONNIE PAIGE
CITY CLERK OF THE CITY OF STOCKTON

BIDDER'S CHECKLIST

CITY OF STOCKTON / PURCHASING DIVISION

Did You:

* ___ Complete the following bid documents (FROM THIS PACKET ONLY SUBMIT PAGES 19 to 30:

* ___ Complete and sign the "Bid to be Submitted" form.

* ___ Sign the "Bidder's Agreement" form. **Include (with bid) name and e-mail address for City contact, if different from signatree**

* ___ Sign and notarize by jurat certificate the "Non-Collusion Affidavit" form. An "All-Purpose Acknowledgment" form will not be sufficient.

* ___ Recheck your math on each item extension and total column. Do not superimpose numerals on your bid forms. If erasures or interlineations appear on your bid form, they must be initialed by the person preparing the bid.

* ___ Answer questionnaire and submit with bid package.

* ___ Submit one (1) ORIGINAL of all bid documents and one (1) CD with an electronic version of the bid documents to the City. Also, submit a similar courtesy copy to Segal.

* ___ Review all clarifications/questions/answers on the City's website at www.stocktongov.com/bidflash

* ___ Deliver sealed bid to City Hall, City Clerk's Office (1st floor), 425 North El Dorado Street, Stockton, CA 95202, before **THURSDAY, OCTOBER 13, 2016, at 2:00 p.m.** Sealed bid shall be marked "Bid" and indicate project name, number, and bid opening date.

Please note that some overnight delivery services do not deliver directly to the City Clerk's Office. This could result in the bid arriving in the City Clerk's Office after the bid opening deadline and therefore not being accepted. NOTE: The Stockton City Clerk's office is closed from 12 noon to 1 p.m. for lunch.

A) BID – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

B) PUR 16-013

C) OCTOBER 13, 2016

For Information on Technical Data or Bid Process/Clarification, contact:

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Concepcion Gayotin, PURCHASING

Tom Morrison, SEGAL

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*If not completed as required, your bid may be voided.

***DISCLAIMER:** The City does not assume any liability or responsibility for errors/omissions in any document transmitted electronically.

*THIS FORM IS FOR YOUR INFORMATION ONLY AND DOES NOT NEED TO BE SUBMITTED WITH YOUR BID.

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1.0 GENERAL INFORMATION

1.1 REQUEST FOR SEALED BIDS

The purpose of this sealed bid is to request bidders to present their qualifications and capabilities to provide **HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ADMINISTRATION SERVICES (PUR16-013)** for the City of Stockton.

1.2 INVITATION TO SUBMIT A BID

Bids shall be submitted no later than **2:00 p.m., on THURSDAY, OCTOBER 13, 2016**, in the office of:

CITY CLERK
CITY OF STOCKTON
425 NORTH EL DORADO STREET
STOCKTON, CA 95202-1997

The bid should be firmly sealed in an envelope which shall be clearly marked on the outside, "HEALTH REIMBURSEMENT ARRANGEMENT (HRA) for the City of Stockton (PUR16-013)." Additionally, submit one (1) CD with an electronic version of the bid documents. Any bid received after the due date and time indicated will not be accepted and will be deemed rejected and returned, unopened, to the bidder.

Also, submit a similar courtesy copy of the bid document and the CD to Segal at:

The Segal Company
c/o Tom Morrison
330 North Brand Blvd., Ste. 1100
Glendale, CA 91203

The timeliness of bid submission and its acceptance will be determined by the City of Stockton. Any portion or documents submitted to Segal, but not submitted to the City of Stockton will not be accepted.

No unsolicited material will be accepted after the submittal date.

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1.3 LOCAL BUSINESS PREFERENCE

Stockton Municipal Code Section 3.68.090 reads as follows:

Preference shall be given to the purchase of supplies, materials, equipment, and contractual services from local merchants, quality and price being equal. Local merchants who have a physical business location within the boundaries of San Joaquin County, and who have applied for and paid a business license tax and registration fee pursuant to Stockton Municipal Code Title 5, Chapter 5.08, License Taxes, shall be granted two (2) percent bid preference. Local merchants who have a physical business location within the boundaries of the City of Stockton, and who have applied for and paid a business license tax and registration fee pursuant to Stockton Municipal Code Title 5, Chapter 5.08, License Taxes, shall be granted five (5) percent bid preference. This section is intended to provide preference in the award of certain City contracts in order to encourage businesses to move into and expand within the City. (Ord. 2014-03-18-1601 C.S. § 1; prior code § 3-106.1)

1.4 CONSEQUENCE OF SUBMISSION OF BID

- A. The City shall not be obligated to respond to any bid submitted nor be legally bound in any manner by the submission of a bid.
- B. Acceptance by the City of a bid obligates the bidder to enter into a contract with the City.
- C. A contract shall not be binding or valid against the City unless or until it is executed by the City and the bidder.
- D. Statistical information contained in these documents is for informational purposes only. The City shall not be responsible for the accuracy of said data. City reserves the right to increase or decrease the project scope.

1.5 EXAMINATION OF BID MATERIALS

The submission of a bid shall be deemed a representation and warranty by the bidder that it has investigated all aspects of the bid, that it is aware of the applicable facts pertaining to the bid process and its procedures and requirements, and that it has read and understands the bid. No request for modification of the provisions of the bid shall be considered after its submission on the grounds the bidder was not fully informed as to any fact or condition. Statistical information which may be contained in the bid or any addendum

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thereto is for informational purposes only. The City disclaims any responsibility for this information which may subsequently be determined to be incomplete or inaccurate.

1.6 ADDENDA AND INTERPRETATION

The City will not be responsible for, nor be bound by, any oral instructions, interpretations, or explanations issued by the City or its representatives. Any request for clarifications/questions/answers of a bid shall be made in writing/e-mail and deliverable to:

Tami Matuska, HUMAN RESOURCES
Concepcion Gayotin, PURCHASING
Tom Morrison, SEGAL

email - Purchasing@stocktonca.gov

Such request for clarification shall be delivered to the City by Sept.29, 2016. Any City response to a request for clarifications/questions/answers will be posted on the City's website at www.stocktongov.com/bidflash by October 6, 2016, and will become a part of the bid. The bidder should await responses to inquiries prior to submitting a bid.

1.7 DISQUALIFICATION

Any of the following may be considered cause to disqualify a bidder without further consideration:

- A. Evidence of collusion among bidders;
- B. Any attempt to improperly influence any member of the evaluation panel;
- C. Any attempt to communicate in any manner with a City of Stockton elected official during the bid process will, and shall be, just cause for disqualification/rejection of bidder's bid submittal and considered non-responsive.
- D. A bidder's default in any operation of a contract which resulted in termination of that contract; and/or

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- E. Existence of any lawsuit, unresolved contractual claim, or dispute between bidder and the City.
- F. No person, firm, or corporation shall be allowed to make or file or be interested in more than one bid for the same supplies, services, or both; provided, however, that subcontract bids to the principal bidders are excluded from the requirements of this section: Section 3.68.120 of the Municipal Code.

1.8 INFORMAL BID REJECTED

A bid shall be prepared and submitted in accordance with the provisions of these bid instructions and specifications. Any alteration, omission, addition, variance, or limitation of, from, or to a bid may be sufficient grounds for rejection of the bid. The City has the right to waive any defects in a bid if the City chooses to do so. The City may not accept a bid if:

- A. Any of the bid forms are left blank or are materially altered;
- B. Any document or item necessary for the proper evaluation of the bid is incomplete, improperly executed, indefinite, ambiguous, or missing.

1.9 CONDITIONS TO BE ACCEPTED IF ANY WORK IS SUBCONTRACTED

- A. The bidder assumes full responsibility, including insurance and bonding requirements, for the quality and quantity of all work performed.
- B. If bidder's supplier(s) and/or subcontractor's involvement requires the use of a licensed, patented, or proprietary process, the bidder of the process is responsible for assuring that the subcontractor, supplier, and/or operator have been properly authorized to use the process or for providing another process which is comparable to that which is required prior to submission of a bid.

1.10 LICENSING REQUIREMENTS

Any professional certifications or licenses that may be required will be the sole cost and responsibility of the successful bidder.

A City of Stockton Business license may be required for this project. Please contact the City of Stockton Business License Division at (209) 937-8313.

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1.11 INSURANCE REQUIREMENTS

Bidder, at Bidder's sole cost and expense and for the full term of the resultant contract or any extension thereof, shall obtain and maintain at least all of the insurance requirements listed in attached Exhibit A.

All coverage shall be provided by a carrier authorized to transact business in California and shall be primary. All policies, endorsements, and certificates shall be subject to approval by the Risk Manager of the City to Stockton as to form and content. These requirements are subject to amendment or waiver if so approved in writing by the Risk Manager.

Maintenance of proper insurance coverage is a material element of this contract, and failure to maintain or renew coverage or to provide evidence of renewal may be treated as a material breach of contract.

The Bidder shall assert that these insurance requirements will be met as part of their response. *Failure to comply with these insurance requirements may result in a bid being deemed unresponsive.* Bidder shall satisfy these insurance requirements concurrently with the signing of the contract prior to commencement of work. *It is strongly suggested that insurance requirements be reviewed with Bidder's broker to ensure any additional costs are included in the pricing component.*

Any questions pertaining to insurance requirements, please contact City of Stockton Risk Services at (209) 937-5037.

1.12 HOLD HARMLESS DEFENSE CLAUSE

Indemnity and Hold Harmless. With the exception that this section shall in no event be construed to require indemnification by CONTRACTOR to a greater extent than permitted under the public policy of the State of California, CONTRACTOR shall, indemnify, protect, defend with counsel approved by CITY and at CONTRACTOR'S sole cost and expense, and hold harmless CITY, its Mayor, Council, officials, representatives, agents employees and volunteers from and against any and all claims, causes of action, liabilities, judgments, awards, losses, liens, claims, stop notices, damages, expenses, and costs (including without limitation attorneys' fees, expert and contractor fees, and other expenses of litigation) of every nature, including, but not limited to, death or injury to persons, or damage to property, which arise out of or are in any way connected with the work performed, materials furnished, or services provided under this Agreement, or from any violation of any federal, state, or municipal law or ordinance, or CITY Policy, by CONTRACTOR or CONTRACTOR'S officers,

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agents, employees, volunteers or subcontractors. CONTRACTOR shall not be obligated to indemnify or defend CITY for claims finally determined by a court of law or arbitrator to arise from the active negligence or willful misconduct of the CITY. It is the intent of the Parties that this indemnity obligation is at least as broad as is permitted under California law. To the extent California Civil Code sections 2782, et seq., limit the defense or indemnity obligations of CONTRACTOR to CITY, the intent hereunder is to provide the maximum defense and indemnity obligations allowed by CONTRACTOR under the law. The indemnity set forth in this section shall not be limited by insurance requirements or by any other provision of this Agreement.

With the exception that this section shall in no event be construed to require indemnification, including the duty to defend, by CONTRACTOR to a greater extent than permitted under the public policy of the State of California, the parties agree that CONTRACTOR'S duty to defend CITY is immediate and arises upon the filing of any claim against the CITY for damages which arise out of or are in any way connected with the work performed, materials furnished, or services provided under this Agreement by CONTRACTOR or CONTRACTOR'S officers, agents, employees, volunteers or subcontractors. CONTRACTOR'S duties and obligations to defend the CITY shall apply regardless of whether or not the issue of the CITY'S liability, breach of this Agreement, or other obligation or fault has been determined. CONTRACTOR shall be immediately obligated to pay for CITY'S defense costs of the claim, including, but not limited to, court costs, attorney's fees and costs, expert contractor and witness fees and costs, other witness fees, document reproduction costs, arbitration fees, and, if after final judgment an appeal is pursued, all of such costs for the appeal. At the conclusion of the claim, if there is any determination or finding of sole active negligence or willful misconduct on the part of the CITY, CITY will then reimburse CONTRACTOR for amounts paid in excess of CONTRACTOR'S proportionate share of responsibility for the damages within 30 days after CONTRACTOR provides CITY with copies of all bills and expenses incurred in the defense of the claim(s). It is agreed between the parties that this reimbursement provision assures CONTRACTOR is not obligated to defend or indemnify CITY in an amount greater than provided for under California law, including, without limitation, California Civil Code sections 2782, 2782.6, and 2782.8.

With the exception that this section shall in no event be construed to require indemnification by CONTRACTOR to a greater extent than permitted under the public policy of the State of California, and in addition to the other indemnity obligations in this Agreement, CONTRACTOR shall indemnify, defend, and hold harmless CITY its Mayor, Council, officials, representatives, agents employees and volunteers from and against all claims, losses, expenses, and costs including but not limited to attorneys' fees, arising out of any claim brought against the CITY by an employee, office, agent, or volunteer of CONTRACTOR, regardless of whether such claim may be covered by any applicable workers compensation

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insurance. CONTRACTOR'S indemnification obligation is not limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for the CONTRACTOR under workers' compensation acts, disability acts, or other employee benefit acts.

1.13 APPLICABLE LAW

This agreement shall be governed by the laws of the State of California. Venue shall be proper in the Superior Court of the State of California, county of San Joaquin, Stockton Branch, or, for actions brought in Federal Court, the United States District Court for the Eastern District of California, Sacramento Division.

1.14 METHOD OF PAYMENT

Payment will be made within thirty (30) days after invoices are received and accepted by the City Manager. Invoices are to be rendered monthly.

1.15 NOTICE TO OUT-OF-STATE BIDDER

The City of Stockton will pay all applicable sales/use tax directly to the State of California for this purchase.

It is the policy of the City of Stockton to pay all applicable California sales/use tax directly to the State Board of Equalization (BOE) pursuant to California Revenue and Taxation Code 7051.3. The City of Stockton will self-accrue all sales/use tax on purchases made from out-of-state bidders.

Sales and use tax on purchases made by the City of Stockton from all companies located outside California and whose products are shipped from out of state will be remitted to the BOE directly by the City under permit number **SR KHE 28-051174 DP**. **Please do not include sales/use tax on the invoice that you submit to the City of Stockton.**

1.16 TERM

Term of the agreement(s) with selected Contractors will commence July 1, 2017 for three years, with an option to renew the contract for two consecutive one-year terms, upon the mutual consent of both parties.

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1.17 COMPETITIVE PRICING

Bidder warrants and agrees that each of the charges, economic or product terms or warranties granted pursuant to this Contract are comparable to or better than the equivalent charge, economic or product term or warranty being offered to any similarly situated commercial or other government customer of bidder. If bidder enters into any arrangements with another customer of bidder to provide product under more favorable charges, economic or product terms or warranties, bidder shall immediately notify CITY of such change and this Contract shall be deemed amended to incorporate the most favorable charges, economic or product terms or warranties.

1.18 FUNDING

Any contract which results from this bid will terminate without penalty at the end of the fiscal year in the event funds are not appropriated for the next fiscal year.

If funds are appropriated for a portion of the fiscal year, this contract will terminate without penalty, at the end of the term for which funds are appropriated.

1.19 UNCONDITIONAL TERMINATION FOR CONVENIENCE

The City may terminate the resultant contract for convenience by providing a sixty (60) calendar day advance notice unless otherwise stated in writing.

1.20 AUDITING OF CHARGES & SERVICES

The City reserves the right to periodically audit all charges and services made by the bidder to the City for services provided under the contract. Upon request, the bidder agrees to furnish the City with necessary information and assistance.

1.21 AWARD

Upon conclusion of the bid process, a contract may be awarded for HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATION SERVICES for the City of Stockton.

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The City reserves the right to make an award on any item, quantity of any item, group of items, or in the aggregate to that/those bidder(s) whose bid(s) is/are most responsive to the needs of the City. Further, the City reserves the right to reject any and all bids, or alternate bids, or waive any informality in the bid as is in the City's best interest.

Consideration will be given in comparing bids and awarding a contract, not only to the dollar amount of the bids, but also to:

- Kind
- Suitability
- Standardization
- Delivery time
- Any other criteria as best suits the City of Stockton
- Compatibility resulting in the lowest ultimate cost; Best value to the City

1.22 CHANGES

The City's Representative has the authority to review and recommend or reject change orders and cost bids submitted by the bidder or as recommended by the bidder's project manager, pursuant to the adopted City of Stockton Standard Specifications.

1.23 OTHER GOVERNMENTAL AGENCIES

If mutually agreeable to all parties, the use of any resultant contract/purchase order may be extended to other political subdivisions, municipalities, or tax supported agencies.

Such participating governmental bodies shall make purchases in their own name, make payment directly to successful bidder and be liable directly to the successful bidder, holding the City of Stockton harmless.

1.24 PRODUCT OWNERSHIP

Any documents, products or systems resulting from the contract will be the property of the City of Stockton.

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1.25 CONFIDENTIALITY

If bidder believes that portions of a bid constitute trade secrets or confidential commercial, financial, geological, or geophysical data, then the bidder must so specify by, at a minimum, stamping in bold red letters the term "**CONFIDENTIAL**" on that part of the bid which the bidder believes to be protected from disclosure. The bidder must submit in writing specific detailed reasons, including any relevant legal authority, stating why the bidder believes the material to be confidential or a trade secret. Vague and general claims as to confidentiality will not be accepted. The City will be the sole judge as to whether a claim is general and/or vague in nature. All offers and parts of offers that are not marked as confidential may be automatically considered public information after the contract is awarded. **The bidder is hereby put on notice that the City may consider all or parts of the offer public information under applicable law even though marked confidential.**

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2.0 BACKGROUND/GENERAL NATURE OF SERVICE

The City has established an HRA Plan as of July 1, 2011. The Plan is intended to qualify as an employer-provided medical reimbursement plan under Code sections 105 and 106 and regulations issued hereunder in the form of a health reimbursement arrangement in accordance with Internal Revenue Service Notice 2002-45. In addition, the assets of this Plan shall be held in a trust established under Code section 115 and shall be an irrevocable trust under applicable law of the State of California. The Trust Fund established under this Plan and the assets hereunder will not be used for, or diverted to, purposes other than the exclusive benefit of Participants.

There are currently 155 employees receiving contributions, and 172 not receiving a current contribution, but with account balances, totaling 327 active accounts.

2.01 PLAN OVERVIEW – PLAN AND TRUST DOCUMENT (ATTACHMENT A)

- A. Eligibility: All employees of the City covered by a collective bargaining agreement, the terms of which provides benefits under a health reimbursement arrangement shall be eligible to participate in the Plan immediately upon hire in an eligible position with the City and shall have Employer contributions made to an HRA Account. Currently, those bargaining units include: Water Supervisory, and Operations and Maintenance, which cover 155 eligible employees.
- B. Contributions: Once an Eligible Employee has met eligibility requirements, the City shall make contributions, as defined in each bargaining unit's Memorandum of Understanding (MOU). The MOU's language pertaining to the HRA is included as **Attachment B** of this specification. Eligible employee salary information will be provided via secure email transmission once the signed Confidentiality Agreement are submitted by the Bidder.
- C. Termination of Participation: A Participant will cease to be a Participant in this Plan upon the earliest of:
1. the date the Eligible Employee's or former Eligible Employee's HRA Account is depleted; or
 2. the employee is not enrolled in a group health plan.
 3. the date the Eligible Employee or former Eligible Employee dies without a surviving Spouse or Eligible Dependent.
 4. the date of termination of this Plan.

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5. employees may continue to use account balances upon retirement or upon separation. However, full withdrawal of funds upon separation are excluded from the provisions.

D. Interface with City:

The selected HRA bidder shall provide “turn-key” services and perform all necessary administrative functions as requested in this BID. The City will interact with the selected bidder and provide appropriate support, as follows:

1. Provide specifications for the City payroll and administrative systems;
2. Determine eligibility and provide enrollment information to selected bidder;
3. Transmit contribution information to selected bidder, at the end of each pay period;
4. Perform contribution money transfers to selected bidder.

2.1 SCOPE OF SERVICES

The City is seeking bids from firms to provide third party administration (“TPA”) services for the Health Reimbursement Arrangement (“HRA”) plan for the City of Stockton’s Water Supervisory, and Operations and Maintenance Units, and all future bargaining units that adopt the model plan. The current eligible active participants should be assumed to be approximately 147 active employees. Balances may be accessed during employment, or after retirement under the current Plan design.

This projected effective contract start date is July 1, 2017.

The scope of work includes, but may not be limited to, the following criteria.

- A. The selected bidder shall provide “turn-key” HRA administration services as follows:
 1. Administer HRA Plan according to plan rules (please refer to Attachment A, Plan Document);

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2. Maintain participant information including all necessary data elements to ensure proper plan administration;
 3. Provide claims procedures information to enrolled participants when they retire;
 4. Process participant requests for reimbursement according to plan and IRS rules;
 5. Maintain records of the City's contributions, interest income, benefit payments and other administrative fee deductions, and resulting account balances of City participants and report the same to the City in a format and frequency acceptable to the City;
 6. Prepare and mail to participating employees quarterly and year end reports of the contributions made by the City and the benefits paid to, or on behalf of participating employees under the plan;
 7. Maintain records of all transactions under the Agreement during the term of the Agreement and subsequent periods in compliance with applicable Local, State and Federal requirements;
 8. Provide debit card(s) and manage all debit card transactions (optional);
 9. Provide online access to account balance information via a secure Internet portal both to plan participants and the City;
 10. Create, print, and stock all necessary forms to carry out plan operations; and
 11. Stay current on legal and regulatory changes affecting HRA plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.
- B. The selected bidder shall provide the City with the information in its custody for use in preparing all returns and reports that are required by the Internal Revenue Service, the Department of Labor and any other federal or state agency. The selected bidder shall assist in the preparation of such returns and reports whenever called upon to do so by the City.
- C. The selected bidder shall provide the following additional services:
1. Provide employee communications material in ready-to-print format such as benefit booklets, newsletters or similar informational materials, web-access to interactive information, new participant letters and informational packets, etc.;

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2. Stay current on legal and regulatory changes affecting HRA plans and advise the City of any regulatory, legal, or procedural change; and
 3. Handle the intake and review of all customer service inquiries and appeals.
- D. Charges are to be stated on a per participant account per month basis only. Fees which are based upon assets or account balances will not be acceptable.
- E. Should you require alternative payment methods, please provide a detailed description of your proposed fee structure in the Cost Section of the Questionnaire.

2.2 SUMMARY OF PROCESS AND REQUIREMENTS

A. Questions

All questions must be submitted via email to the City of Stockton.

Questions will be posted in full, along with the responses on the website.

Inquiries are not to be directed to any individuals affiliated with or employed by Segal. Such unauthorized communication may disqualify the bidder from further consideration. However, Segal reserves the right to discuss any part of any response for the purpose of clarification. Bidders will be given equal access to any communications regarding the bid that take place between Segal and other bidders. All information will be posted in the City of Stockton's Bidflash Page: www.stocktongov.com/bidflash.

B. Bid Content

Bids must contain responses to the Questionnaire of this document, as well as the associated fees under Table 1 of the Bid To Be Submitted page.

C. Bid Submittal

1. Bidder must submit the following by 2 PM (Pacific Standard Time), Thursday, OCTOBER 13, 2016.

To the City: one (1) electronic copy, one (1) signed original

To Segal: one (1) electronic copy, one (1) complete copy of the bid

**REQUEST FOR SEALED BIDS
TO PROVIDE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
ADMINISTRATION SERVICES
FOR THE CITY OF STOCKTON, CALIFORNIA
(PUR 16-013)**

Please submit electronic documents in either Word or Excel format if applicable.

2. Bids must be enclosed in a sealed envelope or package and clearly marked as follows:

**BID – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
PUR 16-013
OCTOBER 13, 2016**

- a. Official copy to: CITY CLERK
CITY OF STOCKTON
425 NORTH EL DORADO STREET
STOCKTON, CA 95202-1997
 - b. Courtesy copy to: TOM MORRISON
THE SEGAL COMPANY
330 NORTH BRAND BLVD, SUITE 1100
GLENDALE, CA 91203
3. No unsolicited material will be accepted after the submittal date.
 4. Bids shall remain confidential until the contract(s), if any, resulting from this process are awarded. Thereafter, all information submitted in response to this bid shall be deemed public record. Please see information under Section 1.29 regarding the submission of confidential or proprietary data.
 5. Bidder, by submitting its bid, agrees that any costs incurred by bidder in responding to this bid are to be borne by the bidder and may not be billed to the City of Stockton.
 6. The bid due date is subject to change. If the bid due date is changed, all known recipients of the original bid will be notified of the new date. The City reserves the right to reject any or all bids.

D. Duration of Bid

All bids will remain in effect and legally binding for at least 180 days from the submittal date.

E. Additional Requirements

1. Business Associate Agreement (BAA) – The successful bidder will be requested to sign a BAA to ensure the bidder's compliance with

**REQUEST FOR SEALED BIDS
TO PROVIDE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
ADMINISTRATION SERVICES
FOR THE CITY OF STOCKTON, CALIFORNIA
(PUR 16-013)**

the HIPAA Privacy and Security rules, as it pertains to Protected Health Information. A draft BAA is in Attachment C.

2. Right to Audit – The successful bidder will be required to allow the City the full right to audit.
3. Plan Rules – The bidder agrees to accept any specified eligibility or benefit rules established by the City. Any proposed modifications to the specified eligibility or benefit must be clearly pointed out in the appropriate section of the bid.
4. Transfer of Records – In the event of contract termination, the administrator agrees to transfer to the City (or to a successor administrator) within 30 days of termination notice all data and participant records necessary for the continued administration of the plans. The administrator must agree to continue operations until the transfer of data has been completed.
5. All record documents and data shall be the property of the City and not the administrator.

BID DOCUMENTS

- A) BID – HEALTH REIMBURSEMENT ARRANGEMENT
- B) PUR 16-013
- D) OCTOBER 13, 2016

COMPANY NAME: _____

CONTACT NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

EMAIL: _____

BID TO BE SUBMITTED

(Page 1 of 3)

I/We agree to provide Health Reimbursement Arrangement Administrative Services for the City of Stockton, in accordance with the provisions and specifications listed in this Bid.

TABLE 1

SUMMARY OF FEES

SERVICE ¹	MONTHLY FEE ²				
	Year 1	Year 2	Year 3	Year 4 (Option)	Year 5 (Option)
1. HRA Administration Services (Per Participant Per Month)					
2. Debit Cards:	<ul style="list-style-type: none"> • Initial Card: \$ _____ • Add'l Card: \$ _____ • Dup Card: \$ _____ 				
3. Other Administrative Fees:					
<ul style="list-style-type: none"> • Communication Materials • Trust administrative fees • Banking charges 					
4. Other Fees					
<ul style="list-style-type: none"> • 800 Number (Specify shared or dedicated) • Postage • Printing of Forms • Other (Specify) 					
5. Total Monthly Fees					
6. Total Annual Fees					

¹ Monthly fees should include all administration services outlined in this request for bid. If you are proposing fees on a bundled basis, which may differ from the suggested breakdown above, please ensure that all services are accounted for and indicate "Included" in the appropriate fee box. Please list in Table 3 any services that you would not provide or that are not included in your fees.

² For capitated quotes, please specify which participant population the fee should apply to (i.e., actives, retirees, per account, etc.).

BID TO BE SUBMITTED

(Page 2 of 3)

TABLE 2

FIRST YEAR SET-UP FEES, IF ANY

SERVICE	SET-UP FEES (Year 1 Only)
1. Initial Set-up Charge*	
2. Development of Communication Materials (e.g., transition announcement letters, etc.)	
3. Other (Specify)	
Total Set-up Fees – All inclusive	

* If proposing a set-up charge, please also include an alternative bid that includes the set-up fees in the flat monthly fees for the 36-month contract.

TABLE 3

FEES AND SERVICES

List of services included in fees
Any special fees, charges or expenses of any kind not included in fees
List of services not included in fees, along with associated fees

BID TO BE SUBMITTED

(Page 3 of 3)

FIRM

ADDRESS

SIGNED BY

TITLE OR AGENCY

DATE

() _____
TELEPHONE

IF YOU DO NOT WISH TO BID, PLEASE RETURN YOUR BID IMMEDIATELY STATING REASON.

BIDDER'S AGREEMENT

In submitting this bid, as herein described, the bidder agrees that:

1. They have carefully examined the specifications and all other provisions of this form and understand the meaning, intent, and requirements of same;
2. They have reviewed and understand all clarifications/questions/answers on the City's website at www.stocktongov.com/bidflash;
3. They will enter into written contract and furnish the item(s)/service(s) in the time specified in strict conformity with the specifications and conditions contained therein for the price quoted by the bidder on this bid;
4. The proposed price is inclusive of all freight and handling charges and includes delivery to the City of Stockton, Human Resources Department, or if specified, to the alternate point of delivery shown in the specifications;
5. They have signed and notarized the attached Non-Collusion Affidavit form whether individual, corporate or partnership. Must be "A Jurat" notarization;

FIRM

ADDRESS

SIGNED BY

TITLE OR AGENCY

E-MAIL ADDRESS

NOTE: Bids are invalid which are unsigned. If erasures or interlineations appear on your bid form, they must be initialed by the person preparing the bid. Bids shall be mailed or delivered to:

**OFFICE OF THE CITY CLERK
FIRST FLOOR, CITY HALL
425 NORTH EL DORADO STREET
STOCKTON, CALIFORNIA 95202-1997**

on or before **2:00 p.m. THURSDAY, OCTOBER 13, 2016**, and publicly opened immediately thereafter in the City Council Chambers. Courtesy copy shall be sent to Segal.

SPECIAL NOTE: U.P.S. OR OTHER SPECIAL HANDLING SERVICES DO NOT DELIVER DIRECTLY TO THE CITY CLERK'S OFFICE. BIDDERS ARE ADVISED THAT IF A SPECIAL HANDLING SERVICE IS USED, BIDS MAY NOT REACH THE CITY CLERK'S OFFICE IN TIME FOR BID OPENING AND WILL BE REJECTED AND RETURNED TO BIDDER.

NON-COLLUSION

No. 1 AFFIDAVIT FOR INDIVIDUAL BIDDER

STATE OF CALIFORNIA, _____)ss.
County of _____)
(insert)

_____ being first duly sworn, deposes and says: That on behalf of any person not named herein; that said Bidder has not colluded, conspired, connived or agreed, directly or indirectly with, or induced or solicited any other bid or person, firm or corporation to put in a sham bid, or that such other person, firm or corporation shall or should refrain from bidding; and has not in any manner sought by collusion to secure to themselves any advantage over or against the City, or any person interested in said improvement, or over any other Bidder.

(Signature Individual Bidder)

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____
by _____, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Seal _____

Signature _____

No. 2 AFFIDAVIT FOR CORPORATION BIDDER

STATE OF CALIFORNIA, _____)ss.
County of _____)
(insert)

_____ being first duly sworn, deposes and says: That they are the _____ of _____ a corporation, which corporation is the party making the foregoing bid, that such bid is genuine and not sham or collusive, or made in the interest or behalf of any person not named herein; that said Bidder has not colluded, conspired, connived or agreed, directly or indirectly with, or induced or solicited any other bid or person, firm or corporation to put in a sham bid, or that such other person, firm or corporation shall or should refrain from bidding; and has not in any manner sought by collusion to secure to themselves any advantage over or against the City, or any person interested in said improvement, or over any other Bidder.

(Signature Corporation Bidder)

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____
by _____, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Seal _____

Signature _____

No. 3 AFFIDAVIT FOR FIRM, ASSOCIATION, OR CO-PARTNERSHIP

STATE OF CALIFORNIA, _____)ss.
County of _____)
(insert)

_____,
each being first duly sworn, depose and say: That they are a member of the firm, association or co-partnership,
designated as _____ who is the party making the foregoing bid; that the other partner, or partners, are _____ that such bid is genuine and not sham or collusive, or made in the interest or behalf of any person not named herein; that said Bidder has not colluded, conspired, connived or agreed, directly or indirectly with, or induced or solicited any other bid or person, firm or corporation shall or should refrain from proposing; and has not in any manner sought by collusion to secure to themselves any advantage over or against the City, or any person interested in said improvement, or over any other Bidder.

(Signature)

(Signature)

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____
by _____, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Seal _____

Signature _____

BID QUESTIONNAIRE
(Page 1 of 6)

A. **QUESTIONNAIRE**

- Provide an answer to each question and do not leave blank or unanswered questions.
- Answer the question as directly as possible and incorporate all information within the questionnaire section. Please avoid referring to attachments or collateral materials in lieu of answers. Do not include promotional materials.
- Clearly identify and label all supplemental attachments and collateral materials with the corresponding questionnaire section and question number.
- The bidder will be held accountable for accuracy/validity of all answers.
- Remember, Bid responses will become part of the contract between the winning bidder and the client.
- Your electronic bid should be submitted using Microsoft Word or other compatible software in a writable format (no PDFs, please).

COMPANY HISTORY AND FINANCIAL PROFILE

1. The firm name, mailing address, telephone number, and the name of the primary contact person and e-mail address.
2. Where is your company located and how long has it been operational?
3. Is your company a division or subsidiary of a parent firm? If yes, please indicate the name of the parent firm.
4. Identify and include roles of all subcontractors you plan to utilize to fulfill the requirements of this BID. What company will provide custodial banking, trust services?
5. Are you licensed to do business in the State of California? What other states are you licensed in?
6. Provide a statement regarding any conflict or potential conflict your firm or any key staff may have regarding provision of proposed services to the City.
7. Provide the latest annual report or other financial reports.
8. Please describe any type of external audits performed of your operations including but not limited to SAS-70 and the frequency of these audits. Please include a copy of your most recent SAS-70 (or other external audit).

BID QUESTIONNAIRE

(Page 2 of 6)

9. What fidelity and surety insurance or bond coverage do you carry to protect your clients?
10. Has your firm or any client administered by your firm ever sustained a fidelity loss or claim? If yes, please provide details.
11. Indicate your firm's liability insurance limit with regard to errors, omission, negligence, etc.
12. In what investment fund are employee contributions deposited? Provide a 2015 average annual yield for the funds

ORGANIZATIONAL EXPERIENCE AND REFERENCES

13. Describe your company's experience administering HRA benefits for public sector entities.
14. Of your company's current clients, what three would be viewed as peer groups for the services requested by the City? Include the following information for each client:
 - a) Client name
 - b) Principal location
 - c) Number of covered participants
 - d) Client contact including name, title and phone number
 - e) Services provided – ***please be specific***
 - f) Effective date of contract
15. Has your firm ever been subject to a legal action brought by a client or former client in the last five years? If so, please explain the nature and current status of the action(s).

HRA ADMINISTRATION

16. All administrative expenses for the operation of the accounts and your company's services are to be debited from the participant account balances. Does your firm agree to this arrangement?
17. Please submit a work plan outlining your ability and approach to providing the HRA administration services outlined in this BID.
18. The City requires that the following services be provided in administering the HRA program. Please complete the following table. Indicate if your organization will perform the following services for the City:

BID QUESTIONNAIRE
(Page 3 of 6)

Service	Will your organization perform the following services? Indicate		Explain the way in which you will provide each of these services
	Yes	No	
Communication to plan members including telephone service	<input type="checkbox"/>	<input type="checkbox"/>	
Web-based on-line tool for enrollment information & inquiries	<input type="checkbox"/>	<input type="checkbox"/>	
Web-based on-line access to employee accounts	<input type="checkbox"/>	<input type="checkbox"/>	
Processing of requests for reimbursement, including eligibility verification including EFT and automatic payment of premiums	<input type="checkbox"/>	<input type="checkbox"/>	
Ongoing record keeping of accounts including quarterly statements	<input type="checkbox"/>	<input type="checkbox"/>	
Issuance of reimbursement drafts and pertinent documentation and EFT	<input type="checkbox"/>	<input type="checkbox"/>	
Employee notification of year-end account balances	<input type="checkbox"/>	<input type="checkbox"/>	
Periodic accounting and statistical reports (include examples) for the City	<input type="checkbox"/>	<input type="checkbox"/>	
Banking arrangement for holding trust deposits to the HRA program	<input type="checkbox"/>	<input type="checkbox"/>	
Reconciliation, audit detail for the City Auditor			

If your bid does not include all of these services, or includes other additional services, please describe in detail. Also, please indicate the cost of each service in the Financial Section. You may refer in each of the answers above to exhibits, which are illustrative samples of the documents reference in your answers.

19. Please describe your claim reimbursement process.

BID QUESTIONNAIRE

(Page 4 of 6)

20. Provide samples of communication materials to be distributed by the bidder to all members including but not limited to:
- Procedures for obtaining reimbursement
 - Procedures for appealing an adverse reimbursement determination
 - Claim forms
 - Claim substantiation when using debit card

CUSTOMER SERVICE

21. What is the location and hours of operation of the office that would provide day-to-day account service?
22. Please describe what online services are available for reviewing account balances and transactions. Please describe your current internet capabilities as they relate to customer service including what features are available, what information can be accessed by the City's Plan Administrator, what information can be accessed by employees, and what information can be updated using the Internet.
23. What hours will the telephone lines be staffed by actual customer service representatives? (Please do not include hours the telephone line will be staffed by an answering service. Include weekend hours, if applicable.)

DEBIT CARDS

24. Do you provide debit card reimbursement capability? What is the additional cost to the participant for these services?
25. Describe your debit card services. Do you provide a proprietary card or do you use an outside bidder?
26. If a debit card is offered, is there a minimum account balance requirement?
27. Describe any substantiation that an individual must provide to you or the plan sponsor.
28. Describe your procedures to correct claim errors, including what notice is provided to the plan sponsors and individual claimant.

BID QUESTIONNAIRE

(Page 5 of 6)

29. Describe which automatic electronic substantiation methods you use in detail:
- Co-payments
 - Recurring claims
 - Real-time substantiation
 - Inventory Information Approval System (IIAS)
30. Are you in compliance with IRS Notice 2006-69? If not, please describe your compliance program.

HIPAA

31. Does your system presently meet requirements in the regulations issued pursuant to the HIPAA Security standards?
32. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?

REPORTING CAPABILITIES

33. What information/reports are available via on-line access to the City?
34. Would you provide ad-hoc data reports at the City's request? If so, please describe your ad-hoc data reporting capabilities. Would there be additional fees for these reports? If so, please describe and include all additional fees in Tables 1 and 3 of the Financial Section.

B. WORK PLAN/TECHNICAL APPROACH

This section should establish your understanding of the City's objectives and requirements, demonstrate your ability to meet those requirements, and outline clearly and concisely the plan for accomplishing the specified work.

1. Do you have a special team assigned to handle the transition of new clients? Who would be in your "City Team" if you were the selected bidder?
2. Please provide a draft implementation schedule.

BID QUESTIONNAIRE

(Page 6 of 6)

C. COST

This section should disclose all charges to be assessed to the participants for the required services. All bids must include a proposed fee schedule of hourly time charges for each class of personnel you would assign. If your fee schedule is calculated differently (for example, a per-employee or flat rate fee), please describe and include the number of personnel provided at the scheduled rate(s).

Bids must detail any items in addition to personnel costs that will be charged to the City, such as travel costs and office expenses. Please also provide hourly time charges for additional services not included within the scope of routine services outlined in this BID. Additional services would be undertaken only at the written request of the City. Describe any special services and/or benefits offered at no cost to the City.

1. Please confirm that:
 - a. All fees are guaranteed for 36 months and additional two option years from contract inception.
 - b. All future rate adjustments will be communicated at least 90 days in advance of the effective date.
 - c. Your fees include printing of benefit statements, enrollment forms, benefits applications, and all other routine supplies and materials. Fees should include printing and mailing costs.
 - d. List all additional fees for debit cards
2. Detail your billing reconciliation responsibilities and procedures. The City will require that all reconciliations be performed by the successful bidder.
3. Confirm that you agree to perform the following functions in the event of cancellation:
 - a. Guarantee a reduced or discounted post-termination administrative fee.
 - b. Transfer all records to the Trustees or the successor administrator within 30 days of termination in a form that is acceptable to the recipient.

Also, detail any rights reserved by your firm to call **any** additional funds.

Exhibit A:
Insurance Requirements
(Health Reimbursement Arrangement HRA Administrator)

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

1. **Commercial General Liability (CGL):** Insurance Services Office Form CG 00 01 covering CGL on an “occurrence” basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than **\$2,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability:** Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **\$1,000,000** per accident for bodily injury and property damage.
3. **Workers’ Compensation** insurance as required by the State of California, with Statutory Limits, and Employer’s Liability Insurance with limit of no less than **\$1,000,000** per accident for bodily injury or disease. ***(Not required if consultant provides written verification it has no employees)***
4. **Professional Liability (Errors and Omissions)** Insurance appropriate to the Consultant’s profession, with limit no less than **\$1,000,000** per occurrence or claim, \$2,000,000 aggregate. (If Claims-made, see below.)
5. **Crime Coverage**, Not less than \$1,000,000 per occurrence.

If the Consultant maintains higher limits than the minimums shown above, the City of Stockton requires and shall be entitled to coverage for the higher limits maintained by the consultant. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City of Stockton.

Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status

The City of Stockton, its Mayor, Council, officers, representatives, agents, employees and volunteers are to be covered as additional insureds on the CGL policy and AL policy with respect to liability arising out of work or operations performed by or on behalf of the Consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Consultant's insurance (**at least as broad as** ISO Form CG 20 10 11 85 or both CG 20 10 and CG 20 37 forms if later revisions used).

Primary Coverage

For any claims related to this contract, the Consultant's insurance coverage shall be endorsed as **primary** insurance as respects the *City of Stockton, its Mayor, Council, officers, representatives, agents, employees and volunteers*. Any insurance or self-insurance maintained by the *City of Stockton, its Mayor, Council, officers, representatives, agents, employees and volunteers* shall be excess of the Consultant's insurance and shall not contribute with it. The City of Stockton does not accept endorsements limiting the Contractor's insurance coverage to the sole negligence of the Named Insured.

Notice of Cancellation

Each insurance policy required above shall state that **coverage shall not be canceled, except with notice to the City of Stockton.**

Waiver of Subrogation

Consultant hereby grants to City of Stockton a waiver of any right to subrogation which any insurer of said Consultant may acquire against the City of Stockton by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City of Stockton has received a waiver of subrogation endorsement from the insurer.

Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions must be declared to and approved by the City of Stockton Risk Services. The City of Stockton may require the Consultant to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

Acceptability of Insurers

Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII if admitted to do business in the State of California; if not admitted to do business in the State of California, insurance is to be placed with insurers with a current A.M. Best's rating of no less than A+:X.

Claims Made Policies

If any of the required policies provide coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.

2. If Claims Made policy form is used, a three (3) year discovery and reporting tail period of coverage is required after completion of work.

Verification of Coverage

Consultant shall furnish the City of Stockton with original certificates and amendatory endorsements required by this clause. All certificates and endorsements are to be received and approved by the City of Stockton Risk Services before work commences. Failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. The City of Stockton reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time, for any reason or no reason.

Consultant shall, prior to the commencement of work under this Agreement, provide the City of Stockton with a copy of its Declarations Page and Endorsement Page for each of the required policies.

Certificate Holder Address

Proper address for mailing certificates, endorsements and notices shall be:

- City of Stockton
- Attention: Risk Services
- 400 E Main Street, 3rd Floor - HR
- Stockton, CA 95202

City of Stockton Risk Services Phone: 209-937-5037

City of Stockton Risk Services Fax: 209-937-8558

Maintenance of Insurance

If at any time during the life of the Contract or any extension, the Consultant fails to maintain the required insurance in full force and effect, all work under the Contract shall be discontinued immediately. Any failure to maintain the required insurance shall be sufficient cause for the CITY to terminate this Contract.

Subcontractors

Consultant shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Consultant shall ensure that City of Stockton is an additional insured on insurance required from subcontractors.

Special Risks or Circumstances

City of Stockton reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

PLAN DOCUMENT

**CITY OF STOCKTON
HEALTH REIMBURSEMENT ACCOUNT PLAN**

FOR UNION EMPLOYEES

PLAN DOCUMENT

ARTICLE I: INTRODUCTION

1.1 *Health Reimbursement Arrangement Status.* This Plan is intended to qualify as a "health reimbursement arrangement" as described at IRS Notice 2002-45, 2002-28 I.R.B. 93. This document restates and amends, as of the Effective Date, the health reimbursement arrangement heretofore maintained by the Employer.

1.2 *Purpose of Plan.* The purpose of this Plan is to reimburse employees for specified uninsured medical expenses.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 **"Administrator"** means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 **"Benefit Dollars"** mean amounts credited to the HRA Account of a Plan Participant that may be used to reimburse the Participant for his or her Eligible Expenses.

2.3 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.4 **"Dependent"** means a Dependent is defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof. Any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) shall be treated as a Dependent of both parents. For purposes of this Plan, "Dependent" also includes any child of a Participant who, as of the end of the current calendar year, will not have attained age twenty-seven.

2.5 **"Effective Date"** means July 1, 2016.

2.6 **"Eligible Employee"** means an Employee who is of the type, category or classification that is eligible to make an election of benefits under the Plan upon satisfying the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, under the Plan. The Employees who are Eligible Employees are all Employees who are members of Stockton Firefighters' Local 456, Stockton Fire Management or Operating Engineers' Local 3-Operations and Maintenance Unit and who are enrolled in a non-HRA group major medical plan maintained by the Employer that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii) (collectively, the "Group Major Medical Plan").

2.7 **"Eligible Expense"** means an expense that qualifies for reimbursement under this Plan, as described in Article IV.

2.8 **"Employee"** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, seasonal employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer but is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

- 2.9 **"Employer"** means the City of Stockton.
- 2.10 **"HRA Account"** means an Account established for a Participant on the records of the Plan to which Benefit Dollars shall be credited and from which claims shall be paid in accordance with Article IV.
- 2.11 **"Minimum Age Requirement"** means the age, if any, that an Eligible Employee must attain as a condition to becoming a Participant. The Plan does not have a Minimum Age Requirement.
- 2.13 **"Minimum Service Requirement"** means the period of continuous employment with the Employer, if any, that an Eligible Employee must complete after becoming an Eligible Employee as a condition to becoming a Participant. The Plan does not have a Minimum Service Requirement.
- 2.13 **"Participant"** means any Eligible Employee who has satisfied the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, and whose Participant Commencement Date has occurred.
- 2.14 **"Participation Commencement Date"** means the date on which an Eligible Employee becomes a Participant, which is the date as of which he or she becomes enrolled in the Group Major Medical Plan.
- 2.15 **"Plan"** means the City of Stockton Health Reimbursement Account Plan for Union Employees as set forth herein, together with any and all amendments and supplements hereto.
- 2.16 **"Plan Year"** means the period on which the records of the Plan are based, which is the twelve-month period commencing on July 1 and ending on the following June 30.
- 2.17 **"Spouse"** means an individual who is treated as a Spouse under the Code.

ARTICLE III: PARTICIPATION

3.1 *Becoming a Participant.* Each Participant may begin to incur Eligible Expenses on his or her Participation Commencement Date.

3.2 *Loss of Eligibility.* A Participant shall become a "Former Participant" on the date that he or she ceases to be an Eligible Employee and thereby shall lose the right to be credited with further Benefit Dollars. A Former Participant who subsequently becomes an Eligible Employee shall be treated as a new Employee for eligibility purposes.

3.3 *Limited Participation Rights After Loss of Eligibility.* A Former Participant may continue to submit claims for the reimbursement of Eligible Expenses from his or her remaining HRA Account balance until the Account is exhausted or until his or her death, whichever is first to occur. If a Participant or Former Participant dies before his or her HRA Account has been exhausted, the balance credited to the HRA Account may be used to pay or reimburse Eligible Expenses subsequently incurred by any surviving Spouse or Dependents of the Former Participant.

The HRA Account balance of a Former Participant shall be forfeited after all duly submitted claims for reimbursement from that Account have been processed.

3.4 *Claims Incurred.* For purposes of this Plan, an expense is "incurred" when the services relating to such expense are rendered.

3.5 *Impact of Leave under the Family Medical Leave Act.* The participation of a Participant who takes a leave of absence from the Employer pursuant to the Family Medical Leave Act ("FMLA") shall continue until the last day of such leave or until the Participant notifies the Employer of his or her intention not to return from the leave, whichever is earlier.

3.6 *Continuation Coverage under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA").* The Plan will comply with the requirements of COBRA or any other applicable federal or state law granting continuation benefits upon termination of coverage to the extent applicable.

3.7 *Right to Opt-Out.* A Participant (or Former Participant who otherwise remains eligible for reimbursement pursuant to Section 3.3) may elect to opt out of and waive all of his or her rights to future reimbursement from the Plan. An opt-out and waiver of benefits hereunder may be communicated to the Plan Administrator during the last month of any Plan Year or at the time of the individual's termination of employment with the Employer.

Any rights to future reimbursement waived pursuant to this Section may be reinstated by the waiving individual as of the date he or she becomes enrolled in Part A or Part B of Medicare, provided notice of the impending enrollment is communicated to the Plan not less than seven days before it is to occur.

ARTICLE IV: BENEFITS

4.1 *Eligible Expenses.* Subject to the limitations set forth below, the Plan shall reimburse a Participant for Eligible Expenses incurred by the Participant or by a Spouse or Dependent of the Participant who also are enrolled in the Group Major Medical Plan. "Eligible Expense" shall mean an expense incurred for medical care as defined in Section 213(d) of the Internal Revenue Code with respect to which neither the Participant nor another person incurring the expense is reimbursed or entitled to reimbursement from any other health plan or arrangement; provided, however, individual major medical insurance premiums, group accident or health insurance premiums that could be paid on a pre-tax basis through a cafeteria plan of the Employer and the cost of drugs or medications, other than insulin, obtained without a prescription shall not be eligible for reimbursement.

4.2 *Maximum Reimbursement Amount.* The amount of benefits payable to a Participant pursuant to Section 4.1 shall not exceed his or her HRA Account balance at the time a claim for benefits is submitted. The HRA Account of a Participant shall consist of a record-keeping entry only and shall not entail any segregation of funds in the name of, or on behalf of, the Participant. No actual or imputed earnings (or losses) shall accrue with respect to such Account.

4.3 *Benefit Dollars.* When an Eligible Employee first becomes a Participant, an HRA Account in his or her name shall be established on the books and records of the Plan. On every pay date of the Employer thereafter, a certain number of Benefit Dollars shall be credited to his or her HRA Account.

The amount of Benefit Dollars so credited shall equal a specified percentage of his or her taxable compensation for the associated payroll period. That specified percentage shall be based on the terms of the collective bargaining agreement between his or her labor union and the Employer in effect on the contribution date.

The HRA Account of a Participant shall be debited by the amount of claims paid to the Participant.

4.4 *Carrying Forward of Account Balances.* Any balance that is credited to the HRA Account of a Participant on the last day of a Plan Year shall be carried forward and credited to his or her HRA Account as of the first day of the succeeding Plan Year.

4.5 *Coordination of Benefits.* Notwithstanding any other provision herein to the contrary, should a Participant incur an eligible expense for purposes of both this Plan and any cafeteria plan, he or she shall be obligated to first submit a claim for reimbursement of that expense by the cafeteria plan and may only submit the expense for reimbursement by the this Plan if the cafeteria plan fails to fully reimburse him or her for the expense.

ARTICLE V: ADMINISTRATION OF PLAN

5.1 *Plan Administrator.* The Plan Administrator shall administer the Plan in accordance with its terms without discriminating among the Participants. The Plan Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

5.2 *Examination of Records.* The Plan Administrator shall make available to each Participant such of his or her records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

5.3 *Reliance on Tables, etc.* In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator.

5.4 *Indemnification of Plan Administrator.* The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by an act or omission to act in connection with the Plan, if such act or omission is in good faith and was not the product of gross negligence.

ARTICLE VI: CLAIMS

6.1 *Filing of Claims.* The Plan Administrator has retained P&A Administrative Services, Inc. of Buffalo, New York (the "Claims Administrator") to process all claims. Information regarding incurred expenses eligible for reimbursement under this Plan shall be submitted directly to the Claims Administrator to determine the amount of any benefits payable hereunder.

If a Participant submits a claim that is incurred while he or she is covered by the Plan pursuant to a continuation coverage provision described in Article III, his or her premium payments for that coverage must be current (subject to any applicable grace period for late payment) to receive reimbursement for that claim.

6.2 *Appeals Procedure.* If a claim for reimbursement is denied in whole or in part, the appeals procedures (including the legally-mandated external review process) described in the Summary Plan Description or Plan Summary, as the case may be, for this Plan shall apply.

6.3 *Scope of Claims Review under this Plan.* Any claim for benefits under any health insurance plan of the Employer shall be governed by the claims procedures that are included in the plan documents pursuant to which that plan is maintained. The claims procedures in this Article shall apply only to (i) any partial or total denial of benefits under this Plan, and (ii) any denial of benefits due to an issue germane to the claimant's eligibility under the Plan.

6.4 *Use of Electronic Payment Card System.* If approved and implemented by the Administrator, Participants may use electronic payment cards to obtain payment of benefits to which they are entitled under the Plan. Any use of electronic payment cards in connection with this Plan shall comply with all pertinent laws, regulations and then current guidance from the Internal Revenue Service.

ARTICLE VII: AMENDMENT AND TERMINATION OF PLAN

The Plan may at any time be amended or terminated by a decision of the governing body of the Employer, provided such amendment or termination does not violate the terms of any collective bargaining agreement.

ARTICLE VIII: MISCELLANEOUS PROVISION

8.1 *Information to be Furnished.* Participants shall provide the Plan Administrator or the Claims Administrator, as the case may be, with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

8.2 *Limitation of Rights.* Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Plan Administrator, except as provided herein.

8.3 *Benefits Solely From General Assets.* Except as may otherwise be required by law:

(a) Nothing herein will be construed to require any fund or segregated amount to be maintained for the benefit of any Participant; and

(b) No Participant or other person shall have any claim against, right to or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be

made.

8.4 *Use and Disclosure of Protected Health Information.*

(a) Members of the Employer's workforce have access to the individually identifiable health information of Participants for Plan administrative functions. When this information is provided by the Plan to the Employer, it is "protected health information" ("PHI"). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following definition of PHI applies for purposes of this Section 8.4:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted under HIPAA. HIPAA and the implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the statutory provisions of which are incorporated herein by reference.

(b) The Plan may disclose to the Employer whether a particular individual is a Participant.

(c) The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests it for the purpose of modifying, amending or terminating the Plan. For this purpose, "Summary Health Information" means information (a) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan, and (b) from which the information described in 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(d) Unless otherwise permitted by law, and subject to the conditions of disclosure described in (e) below, and obtaining written certification in accordance with (g) below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses It only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. The term does not include functions performed by the Employer in connection with any other benefit plan or any employment-related functions.

Notwithstanding any provision of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR section 164.504(f).

(e) The Employer agrees that with respect to any PHI disclosed to it by the Plan (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer shall:

- (1) not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- (2) ensure that any agent, including a subcontractor, to whom the Employer provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

- (3) not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- (4) report to the Plan any unauthorized use or disclosure of PHI that it becomes aware of;
- (5) make PHI available to comply with HIPAA's rights to access in accordance with 45 CFR section 164.524;
- (6) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR section 164.526;
- (7) make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528;
- (8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- (9) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which it disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- (10) ensure that the adequate separation between the Plan and the Employer (the "firewall") required by 45 CFR section 504(f)(2)(iii) is maintained.

The Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

(f) The Employer shall allow the following persons access to PHI: its Supervising Resources Analyst, and any other Employee who needs access to PHI to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll and appeals). No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's disciplinary and termination procedures.

The Employer shall ensure that the provisions of this (f) are supported by reasonable and appropriate security measures.

(g) The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan incorporates the provisions of 45 CFR section 504(f)(2)(ii) and that the Employer agrees to the conditions of disclosure set forth in (e) above.

8.5 *Governing Law.* This Plan shall be construed, administered and enforced according to the laws of the State wherein the principal office or place of business of the Employer is located.

8.6 *Complete Document.* This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Employer document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions, and the remainder of the Plan document shall continue in full force and effect.

**CITY OF STOCKTON
HEALTH REIMBURSEMENT ACCOUNT PLAN**

FOR UNION EMPLOYEES

PLAN SUMMARY

PLAN SUMMARY

The City of Stockton maintains the City of Stockton Health Reimbursement Account Plan for Union Employees. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name:

City of Stockton Health Reimbursement Account Plan for Union Employees

2. Employer/Plan Administrator:

City of Stockton
425 North El Dorado Street
Stockton, CA 95202
209 937-8865

3. Claims Administrator:

The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

You may submit your claims online at P&A's website, www.padmin.com, by logging into your P&A Account or by using your smartphone.

Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 716 855-7105.

4. Plan Year-End:

June 30

THE HEALTH REIMBURSEMENT ACCOUNT PLAN OVERVIEW

The purpose of the Plan is to reimburse you for a portion of your uninsured, out-of-pocket medical expenses.

EFFECTIVE DATE AND PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The Plan started on July 1, 2012. This Summary reflects the terms of the Plan as of July 1, 2016.

WHAT IS THE PLAN YEAR?

“Plan Year” refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on July 1 and ending on the following June 30.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

To be eligible for the Plan, you must be a member of Stockton Firefighters' Local 456, Stockton Fire Management Operating Engineers' Local 3-Operations and Maintenance Unit, or the Water Supervisory Unit and you must be enrolled in one of the Employer's group major medical plans. You will qualify for reimbursement by this Plan as soon as you have met these requirements. Stockton Firefighters' Local 456 and Stockton Fire Management no longer have contributions being made as of July 1, 2016; however, may still have funds on account.

PLAN CONTRIBUTIONS

WHO PAYS FOR THE COST OF PLAN BENEFITS?

All benefits under the Plan are paid by the Employer. However, if you elect the COBRA or USERRA Continuation Coverage described below, you will be required to pay premiums to receive the coverage.

WHO PAYS FOR THE COST OF PLAN ADMINISTRATION?

Plan Participants and former Plan Participants (or surviving family members) with Account balances pay the cost of Plan administration. The fees payable to the Claims Administrator for administering your HRA Account (\$4.50 per month) will be subtracted from your Account.

PLAN BENEFITS

WHAT BENEFITS MAY I RECEIVE UNDER THIS PLAN?

The purpose of the Plan is to reimburse you for a portion of your Eligible Expenses. An “Eligible Expense” is any expense for “medical care” (as defined in the Internal Revenue Code) that is not eligible for payment or reimbursement by any other health plan, with these exceptions:

1. The cost of over-the-counter medicines other than insulin is not covered.
2. Premiums for individual major medical health plan coverage are not eligible for reimbursement.
3. Premiums for group accident or health coverage are not eligible for reimbursement if you could elect to pay them on a pre-tax basis through a cafeteria plan offered by the Employer.

Eligible Expenses for the medical care of your Spouse and Dependents who also are enrolled in a group major medical plan of the Employer are covered as well.

When you first become a Participant, an HRA Account will be established in your name. On every pay date after that while you remain a Participant, the Employer will credit your HRA Account with a certain number of “Benefit Dollars”. As you have Eligible Expenses, you can submit claims to the Plan for reimbursement of those expenses from the Benefit Dollars in your HRA Account.

The amount of Benefit Dollars credited to your HRA Account for a particular payroll period will be equal a specific percentage of your taxable pay during that payroll period. That percentage will be based on the terms of the collective bargaining agreement between your union and the Employer.

If you do not use up all of the Benefit Dollars that are credited to your HRA Account for a particular Plan Year on expenses you have in that Plan Year, your leftover Benefit Dollars will be carried forward and included in your HRA Account for the next Plan Year.

The amount that you may receive when you submit a claim will be limited to the number of Benefit Dollars that are credited to your HRA Account at that time.

Understand that your “Account” exists for record-keeping purposes only and does not involve any actual segregation of funds for your benefit.

WHO IS A SPOUSE AND WHO IS A DEPENDENT?

Only the medical expenses of a Participant, a Participant’s Spouse or a Participant’s Dependent are eligible for reimbursement.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state.

Relatives as Dependents

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement of the expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of this Plan, "Dependent" also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

Non-Relatives as Dependents

To qualify as a Dependent, a person who is not related to a Participant must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;
2. have the same principal residence as the Participant for the entire calendar year;
and
3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

BENEFIT CLAIMS

HOW DO I OBTAIN BENEFITS?

There are two ways to receive benefits under the Plan.

Debit Card Payment Method

When you become a Participant for the first time, you will receive a debit card to use. As

you have Eligible Expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office or a pharmacy). If the provider accepts the card, the provider will swipe the card in a manner similar to the way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Claims Administrator.

These rules apply to your use of the debit card:

1. When you use the card to obtain benefits, you will be certifying to the Plan that you are using it only for payment of Eligible Expenses.
2. You are not excused from the legal requirement that every benefit payment by the Plan must be supported by information that shows who provided you with the eligible product or service, the date you received the product or service and the amount you paid for the product or service. If the information that the Claims Administrator receives electronically about an expense when you swipe the card to pay for that expense is not sufficient, then you will be required to provide the missing information.
3. You will not be required to provide any follow-up information for certain expenses that you have paid for using the card. These are: (a) expenses that match exactly a co-payment amount under your health insurance; (b) repeating expenses that have already been approved by the Plan such as prescription drug refills; and (c) expenses where the information that the Claims Administrator receives electronically when you swipe the card is detailed enough to adequately justify the payment without any further information from you.
4. If you are required to provide additional support for an expense and fail to do so or if the Claims Administrator determines that an expense was ineligible for payment, you will be required to immediately repay the Plan. If you do not repay the Plan, the Employer will withhold the amount involved from your paycheck and, if necessary, the Plan will reduce your right to the payment of future claims. Also, you will lose the right to use the card.
5. You will lose the right to use the card immediately if you become ineligible for the Plan, even though you may have the right to submit further claims after you lose eligibility.

Claim Form Submission Method

You obtain reimbursement for an Eligible Expense by submitting a claim form and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expense. Your claims should be submitted directly to the Claims Administrator. After receiving your claim, the Claims Administrator will determine if the expense is covered and will pay any benefits due you under the Plan.

If your claim arises while you are receiving COBRA Continuation Coverage, your premium payments must be up-to-date (subject to a thirty-day grace period for late payment) to receive benefits.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

WHAT ARE MY RIGHTS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits.

As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claim Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. The reason for the denial;
2. A reference to the provision of the Plan on which the denial was based;
3. A description of any additional material or information that would be needed to approve your claim and an explanation of why it is needed;
4. A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA section 502(a) following a denial on review; and
5. If the Claims Administrator relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request.

Appealing a Claim Denial

You have the right to an internal appeal and, if applicable, an external review to an independent review organization.

An internal appeal must be submitted to the Claims Administrator and must include the following information:

1. Your name and address;
2. a statement that you are disputing a denial of a claim or the Claims Administrator's act or omission;
3. The date of the Claims Administrator's notice denying your claim; and
4. The reasons for your disputing the Claims Administrator's denial of the claim or the Claims Administrator's act or omission.

You should also submit any documentation not previously provided that supports your claim.

Your internal appeal must be delivered to the Claims Administrator within 180 days after you receiving the denial notice or after the Claims Administrator's act or omission. Your internal appeal will be heard and decided by the Claims Administrator's Operations Manager.

If you do not file your internal appeal within this 180-day period, you lose your appeal rights.

Decision on Review

The Claims Administrator's Operations Manager will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Operations Manager may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. The specific reason for the denial on review;
2. A reference to the provision of the Plan on which the denial was based;
3. A statement of your right to review, upon request and at no charge, relevant documents and other information;
4. If the Claims Administrator's Operations Manager relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of

the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request; and

5. A statement of your right to bring an external appeal or a civil action under ERISA Section 502(a).

External Appeals

You have the right to an external review of an internal appeal that is denied unless the denial was based on a failure to meet the Plan's eligibility requirements.

The Claims Administrator's Operations Manager will advise you of the process for requesting an external review when your internal appeal is denied. It must be filed within 4 months after you were provided with his or her response to your internal appeal request, or you will lose your right to request it.

The external reviewer must notify you and the Claims Administrator of its decision within 45 days after it receives your external appeal request. The decision is binding on all parties unless other State or Federal law remedies are available.

UNDER WHAT CIRCUMSTANCES WILL I LOSE THE RIGHT TO SUBMIT CLAIMS?

You will lose eligibility for benefits if you stop working for the Employer as an eligible type of employee or if you cease to have the required group major medical plan coverage. When you lose eligibility:

1. You lose the right to have any further Benefit Dollars credited to your HRA Account.
2. You may continue to submit claims for Eligible Expenses until your HRA Account is exhausted or until you die. If there are Benefit Dollars remaining in your HRA Account at the time of your death, those Benefit Dollars may continue to be used to reimburse your Spouse and Dependents for their Eligible Expenses.

MAY I VOLUNTARILY GIVE UP MY RIGHTS TO RECEIVE BENEFITS?

Yes, you may. During the last month of any Plan Year or at the time you cease to be eligible for the Plan, you may elect to opt-out of the Plan, in which case you will be waiving your right to future reimbursement of eligible expenses.

You may want to do this at some point so that you may purchase health coverage on a public health care exchange and receive government subsidies to help pay your premiums. To exercise this right to opt-out of this Plan, please contact the Plan Administrator to obtain a form that may be used for this purpose.

If you exercise the right to opt-out of the Plan, you may later have your right to Plan benefits reinstated as of the date you enroll in either Part A or Part B of Medicare. To reinstate your rights, you would need to give the Plan Administrator notice of your Medicare enrollment at least 7 days before it occurs.

CONTINUATION COVERAGE

WHAT HAPPENS IF I GO OUT ON FMLA LEAVE?

The Family Medical Leave Act (“FMLA”) entitles certain employees to take unpaid leaves of absence totaling twelve weeks per year for specified personal or family health and child care needs. Your coverage under the Plan during any FMLA leave will continue at no cost to you. However, you will lose coverage (subject to your right to elect COBRA Continuation Coverage) if you fail to return to work at the end of the leave or if you give earlier notice of your intention not to return from the leave.

WHAT HAPPENS IF I TAKE MILITARY LEAVE?

If you take a leave of absence from the Employer in connection with duty in the uniformed services, the Plan will continue to cover you on the same basis as an active employee (except for expenses directly related to the military service, e.g., combat-related injuries) if the period of the leave is expected to be less than thirty one days. For leaves of a longer duration, you may elect to continue coverage in the plan at your own expense for up to twenty-four months. The “uniformed services” are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

MAY I CONTINUE MY PARTICIPATION IN THE PLAN IF I BECOME INELIGIBLE (BECAUSE, FOR EXAMPLE, MY EMPLOYMENT TERMINATES?)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), allows certain individuals to continue their health plan coverage at their own expense when that coverage otherwise would end. The purpose of this section of the Summary is to **explain the COBRA rules that could allow you to continue your coverage under the Health Reimbursement Account Plan at the time you would otherwise lose eligibility.**

COBRA Coverage

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your Spouse will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both); or
5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both);
5. You and your Spouse become divorced or legally separated; or
6. He or she stops being eligible for coverage under the Plan as a "Dependent".

Notifying the Plan Administrator of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

How to Provide Notice

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

The Plan's form titled, "Notice of Qualifying Event", should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

See the information below regarding how the occurrence of a second qualifying event may affect the length of COBRA continuation coverage that is available. Any notice that you provide of a second qualifying event must include the same type of information that was included in your notice of the first qualifying event. The Plan's form titled, "Notice of Second Qualifying Event", should be used to notify the Plan Administrator of a second qualifying event. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the second qualifying event occurs.

See the information below regarding how a determination by the Social Security Administration that a qualified beneficiary is disabled may affect the length of COBRA continuation coverage that is available. Any notice of disability that you provide must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination that he or she is disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form titled, "Notice of Disability Determination", should be used to notify the Plan Administrator of a disability determination. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the Social Security Administration makes its determination and before the end of the first 18 months of COBRA continuation coverage.

Electing COBRA Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately. Also, you or your Spouse may

elect coverage for your minor children.

A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

Length of COBRA Coverage

When the qualifying event is your death, your enrollment in Medicare (Part A, Part B or both), your divorce or legal separation or your Dependent losing eligibility as a Dependent, COBRA coverage lasts for up to 36 months. When the qualifying event is the end of your employment or a reduction in your work hours and you became entitled to Medicare benefits less than 18 months before that qualifying event, COBRA coverage for other family members lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of your employment or reduction in your work hours, COBRA coverage generally lasts for up to 18 months. There are three ways in which this 18-month period of COBRA coverage can be extended.

Second qualifying event extension of 18-month period of COBRA coverage

An 18-month extension of coverage will be available to other family members if a second qualifying event occurs during the first 18 months of their continuation coverage. The maximum amount of total COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include your death, your divorce, your enrollment in Medicare or a child losing status as a Dependent.

If a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days to obtain the extension.

Medicare extension for Spouse and Dependents

If your employment ends or your work hours are reduced within 18 months after you become entitled to Medicare, the maximum coverage period for your Spouse and Dependents will end three years from the date you enrolled in Medicare.

Disability extension of 18-month period of COBRA coverage

An 11-month extension of coverage may be available if you or another family member receiving COBRA is disabled. For the extension to be available, the Social Security Administration ("SSA") must determine that the family member was disabled during the first 60 days of COBRA coverage, and you must notify the Plan Administrator of that fact in writing within 60 days after the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability extension is available, it will apply to the COBRA

coverage of all family members, not just the disabled family member.

You must notify the Plan Administrator within 30 days if the SSA determines that the family member has stopped being disabled at any time before the extension coverage period ends. COBRA coverage for all qualified beneficiaries will terminate when this occurs. The plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) the Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of COBRA coverage

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

Payment for COBRA coverage-First payment

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Payment for COBRA coverage- Periodic payments

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Grace periods for periodic payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MISCELLANEOUS

WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A CAFETERIA PLAN OF THE EMPLOYER?

If you have an expense that is an eligible expense under a cafeteria plan as well as under this Plan, the expense must be reimbursed by the cafeteria plan to the extent that you are eligible for reimbursement of expenses under that plan.

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

The Employer may amend or terminate the Plan only under circumstances that will not violate the terms of any collective bargaining agreement between the Employer and a union that represents Plan Participants.

WHAT OTHER RULES APPLY TO MY PARTICIPATION?

MATERNITY BENEFITS

Under federal law, group health plans (including this Plan) and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the

mother and newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that authorization be obtained from the plan or the insurance issuer for prescribing a length of stay not in excess of these periods.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.

MEMORANDUM OF UNDERSTANDING

- 1) Water Supervisory Unit
- 2) Operations & Maintenance Unit

WATER SUPERVISORY UNIT SUCCESSOR MOU; 14.7 Health Reimbursement Account (HRA):

The City will contribute an amount equal to five and one half percent (5.5%) of the employee's current base salary into an IRS qualified HRA for each employee to use for reimbursement of current and retiree medical cost reimbursement.

OPERATIONS AND MAINTENANCE UNIT MOU, provision 14.7. Health Reimbursement Account – HRA:

As soon as administratively possible, the City will contribute an amount equal to five and one half percent (5.5%) of the employee's current base salary that was previously contributed to deferred compensation and redirect that same contribution into an IRS qualified HRA for each employee to use for reimbursement of current and retiree medical cost reimbursements.

BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT (“Agreement”) is entered into as of the date set forth below by and between City of Stockton (“City”) and [Insert Vendor Name] (“Vendor”).

WHEREAS the City is a group health plan or a plan sponsor of one or more group health plans, which group health plan(s) is a Covered Entity as such term is defined in 45 CFR §160.103. For purposes of this Agreement, the term City refers to the group health plan(s) that is the Covered Entity;

WHEREAS Vendor provides services to the City in accordance with the underlying services agreement (the “Services Agreement”), and is a Business Associate, as such term is defined in 45 CFR §160.103, of the City when it conducts such services (the “Services”);

WHEREAS, to perform the Services, Vendor needs to access, use, disclose and maintain Protected Health Information (“PHI”), as such term is defined below; and

WHEREAS access to, and use, disclosure and maintenance of, PHI, electronic transmission and storage of PHI, and security of PHI are regulated by the provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH”), Vendor and the City desire to exchange and treat PHI in compliance with HIPAA and HITECH under the Privacy, Security and Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164 (the “HIPAA Rules”).

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, the City and Vendor hereby agree as follows:

I. 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 [Insert Vendor Name].
- 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 the City.
- C. All terms used and not otherwise defined herein shall have the same meaning as in the HIPAA Rules.

II. Permitted Uses and Disclosures by Vendor

- A. Vendor shall not use or disclose PHI other than as permitted or required by this Agreement and agrees to use and disclose the minimum necessary PHI required.
- B. In particular:
 - i. Vendor may use or disclose PHI as necessary to provide the Services set forth in the Services Agreement.
 - ii. Vendor may use or disclose PHI as Required by Law.
 - iii. Vendor may not use or disclose PHI in a manner that would violate the Privacy Rule if done by the City, except for the specific uses and disclosures set forth herein at subsections iv, v and vi.
 - iv. Vendor may use PHI for its proper management and administration or to carry out its legal responsibilities.
 - v. Vendor may disclose PHI for its proper management and administration or to carry out its legal responsibilities, provided the disclosures are Required by Law, or Vendor 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 Vendor of any instances of which it is aware in which the confidentiality of the information has been violated;
 - vi. Vendor may use and disclose PHI for purposes of data aggregation services relating to the health care operations of the City.
 - vii. Vendor may de-identify PHI in accordance with the requirements of 45 CFR §164.514(a)-(c), and may use or disclose the information that has been de-identified.

III. Obligations and Activities of Vendor

- A. Vendor shall use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by the Agreement
- B. Vendor will report to the City any use or disclosure of PHI not provided for by the Agreement of which it becomes aware.
- C. Vendor shall comply with the Security Rule with respect to electronic Protected Health Information (“ePHI”) and shall report to the City any Security Incident of which it becomes aware. For purposes of reporting under this Section, the definition of Security Incident shall be limited to the successful unauthorized access, use,

disclosure, modification, or destruction of information or interference with system operations in an information system.

- D. Vendor shall report to the City, as soon as practicable, but no later than 30 days after discovery, any Breach of Unsecured PHI as required at 45 CFR §164.410. Such notice shall include all available information required, including:
 - i. The identity of each Individual whose Unsecured PHI has been or is reasonably believed by Vendor to have been accessed, acquired, used or disclosed during the Breach;
 - ii. A brief description of what happened, including the date of the Breach and the date of discovery if known;
 - iii. A description of the type of Unsecured PHI involved in the Breach;
 - iv. The steps Individuals should take to protect themselves from potential harm resulting from the Breach;
 - v. A brief description of the steps Vendor is taking to investigate, mitigate harm, and protect against further breaches; and
 - vi. Contact information for follow-up questions.
- E. If Vendor uses subcontractors in the provision of the Services, Vendor shall ensure that subcontractors who create, receive, maintain, or transmit PHI on its behalf agree to equivalent restrictions, conditions, and requirements as contained herein with respect to such information.
- F. Vendor shall make available to the City PHI in a Designated Record Set as necessary to satisfy City's obligations under 45 CFR §164.524.
- G. Vendor shall make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the City pursuant to 45 CFR §164.526, or take other reasonable measures as necessary to satisfy the City's obligations under 45 CFR §164.526.
- H. Vendor shall maintain and make available to the City information required to provide an accounting of disclosures, as necessary to satisfy City's obligations under 45 CFR §164.528.
- I. Vendor shall only carry out City's obligations under the Privacy Rule as mutually agreed to by the parties. In such instances, Vendor shall comply with the Privacy Rule requirements that apply to the City in the performance of such obligations.
- J. Subject to any applicable legal privileges or confidentiality agreements, Vendor shall, upon reasonable notice and during normal business hours, make its internal practices,

books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules by Vendor and/or the City.

IV. Obligations and Activities of the City

- A. The City shall notify Vendor of any limitation(s) in its notice of privacy practices under 45 CFR §164.520, to the extent that such limitation may affect Vendor's use or disclosure of PHI.
- B. The City shall notify Vendor 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 Vendor's use or disclosure of PHI.
- C. The City shall notify Vendor of any restriction on the use or disclosure of PHI that it has agreed to or is required to abide by under 45 CFR §164.522, to the extent that such restriction may affect Vendor's use or disclosure of PHI.
- D. The City shall not request Vendor to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the City, except to the extent that such use or disclosure is for the purposes set forth above in Section II.B. iv, v and vi.

V. Term and Termination

- A. The Term of this Agreement shall be effective as of the date set forth below and shall run concurrently with the Services Agreement, unless this Agreement is terminated earlier due to the violation of a material term as provided for in Section B below.
- B. Either party may terminate this Agreement if the other violates a material term of the Agreement, provided that the non-breaching party provides the breaching party with no less than 30 days in which to cure such violation prior to termination becoming effective. However, if the non-breaching party reasonably and in good faith determines that the violation is not curable, it may terminate this Agreement immediately upon written notice to the breaching party.
- C. Upon termination of this Agreement, the Services Agreement also shall terminate to the extent that it requires Vendor to access, use, disclose and/or maintain PHI in order to provide the Services.
- D. Upon termination of this Agreement for any reason, Vendor, with respect to any PHI either received from the City, or created, maintained, or received by Vendor on City's behalf, shall:
 - i. Where feasible, return or destroy the PHI, which Vendor still maintains in any form. The City understands that Vendor's need to maintain portions of the PHI in

records of actuarial determinations and for other archival purposes related to memorializing advice provided will render return or destruction infeasible.

- ii. Continue to use appropriate safeguards and comply with the Security Rule with respect to ePHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Vendor retains the PHI; and
 - iii. Not use or disclose the PHI retained other than for the purposes for which such PHI was retained and subject to the same conditions set out in Section II.B.iv and v of this Agreement which applied prior to termination.
- E. The parties' respective obligations under this Section V shall survive the termination of this Agreement.

VI. Miscellaneous

- A. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules 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 from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law. Any amendment shall be in a writing duly executed by both parties.
- C. Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules. In the event of any inconsistency or conflict between this Agreement, and the Services Agreement or any other written agreement between the parties, the terms, provisions and conditions of this Agreement shall control and govern.
- D. Third Party Beneficiaries. Nothing in this Agreement shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of the City.
- E. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile or Portable Document Format (PDF) copies thereof shall be deemed to be originals.
- F. Informal Resolution. If any controversy, dispute, or claim arises between the parties with respect to this Agreement, the parties shall make good faith efforts to resolve such matters informally.
- G. Remedies. Neither party shall be liable to the other party for any incidental, consequential or punitive damages of any kind or nature, whether such liability is

asserted on the basis of contract, tort (including negligence or strict liability), or otherwise, even if the other party has been advised of the possibility of such loss or damages.

- H. Notices. All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by courier service. If to the City, the notice shall be sent to the address set forth below City's signature or such other address as the City notifies Vendor of in writing. If to Vendor, the notice shall be sent to the address set forth below.

[Execution Page Follows]

INTENDING TO BE LEGALLY BOUND, the parties have duly executed this Agreement.

City of Stockton

[Vendor]

Signed _____

Signed _____

Print Name _____

Print Name _____

Title _____

Title _____

Date _____

Date _____

Address _____

Address _____
