AGENDA
EL SEGUNDO CITY COUNCIL
COUNCIL CHAMBERS - 350 Main Street

The City Council, with certain statutory exceptions, can only take action upon properly posted and listed agenda items. Any writings or documents given to a majority of the City Council regarding any matter on this agenda that the City received after issuing the agenda packet are available for public inspection in the City Clerk’s office during normal business hours. Such Documents may also be posted on the City’s website at www.elsegundo.org and additional copies will be available at the City Council meeting.

Unless otherwise noted in the Agenda, the Public can only comment on City-related business that is within the jurisdiction of the City Council and/or items listed on the Agenda during the Public Communications portions of the Meeting. Additionally, the Public can comment on any Public Hearing item on the Agenda during the Public Hearing portion of such item. The time limit for comments is five (5) minutes per person.

Before speaking to the City Council, please come to the podium and state: Your name and residence and the organization you represent, if desired. Please respect the time limits.

Members of the Public may place items on the Agenda by submitting a Written Request to the City Clerk or City Manager’s Office at least six days prior to the City Council Meeting (by 2:00 p.m. the prior Tuesday). The request must include a brief general description of the business to be transacted or discussed at the meeting. Playing of video tapes or use of visual aids may be permitted during meetings if they are submitted to the City Clerk two (2) working days prior to the meeting and they do not exceed five (5) minutes in length.

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact City Clerk, 524-2305. Notification 48 hours prior to the meeting will enable the City to make reasonable arrangements to ensure accessibility to this meeting.

REGULAR MEETING OF THE EL SEGUNDO CITY COUNCIL
TUESDAY, FEBRUARY 1, 2011 – 5:00 P.M.

Next Resolution # 4708
Next Ordinance # 1459

5:00 P.M. SESSION

CALL TO ORDER

ROLL CALL

PUBLIC COMMUNICATION – (Related to City Business Only – 5 minute limit per person, 30 minute limit total) Individuals who have received value of $50 or more to communicate to the City Council on behalf of another, and employees speaking on behalf of their employer, must so identify themselves prior to addressing the City Council. Failure to do so shall be a misdemeanor and punishable by a fine of $250.
SPECIAL ORDER OF BUSINESS:

CLOSED SESSION:
The City Council may move into a closed session pursuant to applicable law, including the Brown Act (Government Code Section §54960, et seq.) for the purposes of conferring with the City’s Real Property Negotiator; and/or conferring with the City Attorney on potential and/or existing litigation; and/or discussing matters covered under Government Code Section §54957 (Personnel); and/or conferring with the City’s Labor Negotiators; as follows:

CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov’t Code §54956.9(a)) -1- matter

1. City of El Segundo vs. City of Los Angeles, et. al. LASC Case No. BS094279

CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Government Code §54956.9(b): -1- Initiation of litigation pursuant to Government Code §54956.9(c): -0- matter.

PUBLIC EMPLOYMENT (Government Code § 54957) – 1- matter (Request for unpaid leave pursuant to El Segundo Municipal Code § 1-6-20). Position/Title: Construction Coordinator

APPOINTMENT OF PUBLIC EMPLOYEE (Gov’t. Code § 54957) -1- matter
Position/Title: City Manager

CONFERENCE WITH CITY’S LABOR NEGOTIATOR (Gov’t Code §54957.6): -0- matters

CONFERENCE WITH REAL PROPERTY NEGOTIATOR (Gov’t Code §54956.8): -0- matters
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REGULAR MEETING OF THE EL SEGUNDO CITY COUNCIL
TUESDAY, FEBRUARY 1, 2011 - 7:00 P.M.

Next Resolution # 4708
Next Ordinance # 1459

7:00 P.M. SESSION

CALL TO ORDER

INVOCATION – Pastor Rob McKenna, El Segundo Foursquare Church

PLEDGE OF ALLEGIANCE – Mayor Pro Tem Bill Fisher
PRESENTATIONS

a. Proclamation proclaiming Friday, February 4, 2011, as National Wear Red Day

ROLL CALL

PUBLIC COMMUNICATIONS – (Related to City Business Only – 5 minute limit per person, 30 minute limit total) Individuals who have received value of $50 or more to communicate to the City Council on behalf of another, and employees speaking on behalf of their employer, must so identify themselves prior to addressing the City Council. Failure to do so shall be a misdemeanor and punishable by a fine of $250. While all comments are welcome, the Brown Act does not allow Council to take action on any item not on the agenda. The Council will respond to comments after Public Communications is closed.

A. PROCEDURAL MOTIONS

Consideration of a motion to read all ordinances and resolutions on the Agenda by title only.
Recommendation – Approval.

B. SPECIAL ORDERS OF BUSINESS (PUBLIC HEARING)

C. UNFINISHED BUSINESS

D. REPORTS OF COMMITTEES, COMMISSIONS AND BOARDS

E. CONSENT AGENDA

All items listed are to be adopted by one motion without discussion and passed unanimously. If a call for discussion of an item is made, the item(s) will be considered individually under the next heading of business.
1. Warrant Numbers 2580728 to 2580879 on Register No. 8 in the total amount of $828,479.21 and Wire Transfers from 01/06/11 through 01/20/11 in the total amount of $2,269,452.96.
Recommendation – Approve Warrant Demand Registers and authorize staff to release. Ratify Payroll and Employee Benefit checks; checks released early due to contracts or agreement; emergency disbursements and/or adjustments; and wire transfers.

2. Regular City Council Meeting Minutes of January 18, 2011.
Recommendation – Approval.

3. Consideration and possible action regarding acceptance of the project for the rehabilitation of Grand Avenue from Sepulveda Boulevard to Duley Road. Project No.: PW 10-03 (Fiscal Impact: $338,365.52)
Recommendation – (1) Accept the work as complete; (2) Authorize the City Clerk to file a Notice of Completion in the County Recorder’s Office; (3) Alternatively, discuss and take other action related to this item.

4. Consideration and possible action regarding the acceptance of $39,810 in grant funding from the U.S. Department of Homeland Security, through the Office of Grants and Training, under Fiscal Year 2008 and 2009 State Homeland Security Grant Programs (SHSGP) to pursue regional training and radio programming. (Fiscal Impact: $39,810)
Recommendation – (1) Authorize the acceptance of $39,810 in grant funds from the SHSGP 2008 and SHSGP 2009 grant programs; (2) Authorize the City Manager to sign an Agreement with the County of Los Angeles who will serve as grant administrator for both grants; (3) Alternatively, discuss and take other action related to this item.

5. Consideration and possible action to adopt Ordinance No. 1458 approving Environmental Assessment EA 881, Specific Plan Amendment No. 10-01, and Zone Text Amendment ZTA 10-04 to amend the Smoky Hollow Specific Plan Land Use Plan and the El Segundo Municipal Code ("ESMC") regulating the permitted uses in the Small Business (SB) and Medium Manufacturing (MM) Zones (Fiscal Impact: N/A)
Recommendation – (1) Waive second reading and adopt Ordinance No. 1458 for Environmental Assessment EA 881, Specific Plan Amendment No. 10-01, and Zone Text Amendment ZTA 10-04; (2) Alternatively, discuss and take other possible action related to this item.
6. Consideration and possible action regarding approval of a Resolution amending the City's Flexible Benefit Plan Document and Summary Plan Description to reflect changes resulting from the Affordable Care Act of 2010 eliminating the reimbursement of over-the-counter medicine or drugs from the health spending account. Fiscal Impact: None Recommendation – (1) Adopt the Resolution; (2) Alternatively, discuss and take other action related to this item.

CALL ITEMS FROM CONSENT AGENDA

F. NEW BUSINESS

7. Consideration and possible action to (1) determine which residential properties will receive City-provided trash collection services when the City's current residential trash collection contract expires on July 31, 2011; (2) approve the Trash Subcommittee's recommendation to bid out the contract for trash collection services and select one of the Subcommittee's bidding options for a new trash collection contract to begin August 1, 2011. (Fiscal Impact: Unknown; fiscal impact to the City estimated at $444,906 to $561,000 depending on City Council Action(s) taken on this agenda item.) Recommendation – (1) Direct staff to either include or exclude City-provided trash services for three and four unit properties in the next residential trash hauling contract; (2) Approve the Trash Subcommittee's recommendation to bid out the contract for trash collection services and select one of the bidding options developed by the Subcommittee for a new trash collection contract to begin August 1, 2011; (3) Alternatively, discuss and take other action related to this item.

G. REPORTS – CITY MANAGER

H. REPORTS – CITY ATTORNEY

I. REPORTS – CITY CLERK

J. REPORTS – CITY TREASURER
K. REPORTS – CITY COUNCIL MEMBERS

Council Member Fuentes –

Council Member Brann –

Council Member Jacobson –

Mayor Pro Tem Fisher –

Mayor Busch –

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MEMORIALS –

CLOSED SESSION

The City Council may move into a closed session pursuant to applicable law, including the Brown Act (Government Code Section §54960, et seq.) for the purposes of conferring with the City’s Real Property Negotiator; and/or conferring with the City Attorney on potential and/or existing litigation; and/or discussing matters covered under Government Code Section §54957 (Personnel); and/or conferring with the City’s Labor Negotiators.

REPORT OF ACTION TAKEN IN CLOSED SESSION (if required)

ADJOURNMENT

POSTED:
WHEREAS, Diseases of the heart are the nation’s leading cause of death and stroke is the fourth leading cause of death; and

WHEREAS, Cardiovascular disease claims the lives of nearly 421,000 American females each year, approximately one death per minute; and

WHEREAS, each year, 52% of all deaths due to cardiovascular and 60% of stroke deaths occur in females and too many women die each year because they are unaware that heart disease is their No. 1 killer; and

WHEREAS, in 2007, the direct and indirect cost of cardiovascular diseases in the U.S., including stroke, is estimated to be $286 billion; and

WHEREAS, nearly as many women die of heart disease, stroke, and all other cardiovascular diseases than the next four leading causes of death combined, including all cancers; and

WHEREAS, only 16% of women surveyed in 2009 identified cardiovascular disease as the greatest health risk problem facing them; and

WHEREAS, February is designated as American Heart Month; and

WHEREAS, Go Red For Women is the American Heart Association’s national call to increase awareness about heart disease – the leading cause of death for women – and to inspire women to take charge of their heart health; and

WHEREAS, all women should learn their own personal risk of heart disease, using tools such as the American Heart Association’s My Life Check, Go Red For Women Heart Check-Up, Go Red For Women Better U and by talking to their healthcare provider; and

WHEREAS, making the right choices relating to proper nutrition, physical activity, and other healthy lifestyle choices are essential to living a heart healthy life.

NOW, THEREFORE, the Mayor and Members of the City Council of the City of El Segundo, California, hereby proclaim Friday, February 4, 2011, as “NATIONAL WEAR RED DAY” in El Segundo and urge all citizens to show their support for women and the fight against heart disease by commemorating this day by the wearing of the color red. By increasing awareness, speaking up about heart disease, and empowering women to reduce their risk for cardiovascular disease, we can save thousands of lives each year.
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**DATE OF RATIFICATION: 02/01/11**
**TOTAL PAYMENTS BY WIRE:**

2,269,452.96

Certified as to the accuracy of the wire transfers by:

Deputy City Treasurer

Director of Finance

City Manager

Information on actual expenditures is available in the City Treasurer's Office of the City of El Segundo.
REGULAR MEETING OF THE EL SEGUNDO CITY COUNCIL
TUESDAY, JANUARY 18, 2011 – 5:00 P.M.

5:00 P.M. SESSION

CALL TO ORDER – Mayor Pro Tem Fisher at 5:00 p.m.

ROLL CALL

Mayor Busch - Present arrived at 5:01 pm
Mayor Pro Tem Fisher - Present
Council Member Brann - Present
Council Member Fuentes - Present
Council Member Jacobson - Present arrived at 5:01 pm

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SPECIAL ORDER OF BUSINESS:

Mark Hensley announced that Council would be meeting in closed session pursuant to the items listed on the agenda and that the Government Code §54956.9(b) item related to facts and circumstances arising from the Initiative Petition seeking to require the City to turn it’s Fire Services over to the County and the fact that the petition did not include a request for a special election.

CLOSED SESSION:
The City Council moved into a closed session pursuant to applicable law, including the Brown Act (Government Code Section §54960, et seq.) for the purposes of conferring with the City’s Real Property Negotiator; and/or conferring with the City Attorney on potential and/or existing litigation; and/or discussing matters covered under Government Code Section §54957 (Personnel); and/or conferring with the City’s Labor Negotiators; as follows:

CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov’t Code §54956.9(a) -1- matter

1. City of El Segundo vs. City of Los Angeles, et. al. LASC Case No. BS094279

CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Government Code §54956.9(b): -1- matter.

Initiation of litigation pursuant to Government Code §54956.9(c): -1- matter.

APPOINTMENT OF PUBLIC EMPLOYEE (Gov’t. Code § 54957) -1- matter
Position/Title: City Manager

CONFERENCE WITH CITY’S LABOR NEGOTIATOR (Gov’t Code §54957.6): -0- matters

CONFERENCE WITH REAL PROPERTY NEGOTIATOR (Gov’t Code §54956.8): -0- matters

Council recessed at 6:50 p.m.
REGULAR MEETING OF THE EL SEGUNDO CITY COUNCIL
TUESDAY, JANUARY 18, 2011 - 7:00 P.M.

7:00 P.M. SESSION

CALL TO ORDER – Mayor Busch at 7:00 p.m.

INVOCATION – Pastor Scott Lambert, Hilltop Church of Christ

PLEDGE OF ALLEGIANCE – Council Member Carl Jacobson

PRESENTATIONS

a. Council Member Carl Jacobson introduced Julie Warner El Segundo Chamber of Commerce who presented trophies to the 2010 Holiday Parade winners.

b. Council Member Fisher presented an official Commendation to Peter and Edna Freeman for their years of community service to the City of El Segundo.

c. Mayor Busch presented an official Commendation to Cathy Domann for her achievement of Municipal Master Clerk designation.

ROLL CALL

Mayor Busch - Present
Mayor Pro Tem Fisher - Present
Council Member Brann - Present
Council Member Fuentes - Present
Council Member Jacobson - Present

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Joe Svezia; spoke regarding trash hauling and the RFP process to possibly select a new residential trash hauler.

Bryan Partlow, Fire Initiative proponent; spoke regarding the signature gathering process and their intent on the circulation of the petition by obtaining the required 15% of the registered voters for a special election. They did not request a special election but
urge the Council to place this on the ballot at the earliest possible election, June, 2011 statewide election.

Chris Thomason, President of the Fire Fighters Association; urged Council to place the Fire Initiative on the June, 2011 statewide election.

Mona Ryan; representing the El Segundo High School Band, requested that Council wave the banner charge for their fun raising event.

Mike Robbins, resident; spoke against the Fire Initiative.

Marc Renner, resident; spoke against the Fire Initiative.

Dave Atkinson; resident; spoke regarding the Proposition 218 ballot counting process and against the Fire Initiative.

Ron Swanson, resident; spoke regarding the parade awards; spoke against speakers coming to the podium, making negative comments and having bad manners.

A. PROCEDURAL MOTIONS

Consideration of a motion to read all ordinances and resolutions on the Agenda by title only.

MOTION by Council Member Brann, SECOND by Council Member Jacobson to read all ordinances and resolutions on the agenda by title only. MOTION PASSED BY UNANIMOUS VOICE VOTE. 5/0

B. SPECIAL ORDERS OF BUSINESS (PUBLIC HEARING)

1. Consideration and possible action to open a public hearing and receive testimony regarding: 1) an Environmental Assessment for a proposed Negative Declaration; 2) a Specific Plan Amendment amending the Smoky Hollow Specific Plan Land Use Plan; and 3) a Zone Text Amendment amending the El Segundo Municipal Code (“ESMC”) regulating the permitted uses in the Small Business (SB) and Medium Manufacturing (MM) Zones. Applicant: Matt Crabbs (Fiscal Impact: N/A)

Mayor Busch stated that this was the time and place to conduct a public hearing and receive testimony regarding: 1) an Environmental Assessment for a proposed Negative Declaration; 2) a Specific Plan Amendment amending the Smoky Hollow Specific Plan Land Use Plan; and 3) a Zone Text Amendment amending the El Segundo Municipal Code (“ESMC”) regulating the permitted uses in the Small Business (SB) and Medium Manufacturing (MM) Zones. Applicant: Matt Crabbs (Fiscal Impact: N/A)

City Clerk Mortesen stated that proper notice had been given in a timely manner and that one written communication has been received in the City Clerk’s Office.
Council Member Jacobson left the dais at 7:53 p.m. and did not participate in the item due to a possible conflict of interest.

Greg Carpenter, Planning and Building Safety Director, and Paul Samaras gave a report.

Matt Crabs, Applicant; spoke about the project.

Bill Messori, Vice President, Mar Ventures; supported the zone change amendment.

MOTION by Council Member Brann, SECONDED BY Mayor Pro Tem Fisher to close the public hearing. MOTION PASSED BY UNANIMOUS THE FOLLOWING VOICE VOTE: AYES: BUSCH, FISHER, BRANN, FUENTES. NOES: NONE. NOT PARTICIPATING: JACOBSON. 4/0/1

Mark Hensley, City Attorney, read by title only:

ORDINANCE NO. 1458

AN ORDINANCE APPROVING A SPECIFIC PLAN AMENDMENT AND A ZONE TEXT AMENDMENT TO AMEND THE SMOKY HOLLOW SPECIFIC PLAN AND THE PERMITTED USES IN THE SMALL BUSINESS (SB) AND MEDIUM MANUFACTURING (MM) ZONES TO ALLOW ART STUDIOS AND A WIDER RANGE OF OFFICES USE.

Council Member Brann introduced the ordinance.

Second reading and adoption scheduled for February 1, 2011.

Council Member Jacobson returned to the dias at 8:07 p.m.

2. Consideration and possible action regarding a public hearing related to the Proposition 218 majority protest ballot process for Residential Trash Collection. (Fiscal Impact: Up to $560,700 in annual savings if the fee is imposed.)

Mayor Busch stated that this was the time and place to conduct a public hearing related to the Proposition 218 majority protest ballot process for Residential Trash Collection. (Fiscal Impact: Up to $560,700 in annual savings if the fee is imposed.)

City Clerk Mortesen stated that proper notice had been given in a timely manner and that no communications had been received in the City Clerk’s Office.

Mark Hensley, City Attorney gave a brief report.

Mike Robbins, resident; requested the returned protest ballots be posted to the web and include the protestor’s name and address. Also spoke against the trash fees.
Marc Renner, Resident; spoke against the trash fees.

Thomas Jolly, Resident; spoke regarding a Wall Street Journal article regarding trash hauling and trash containers and read it into the record.

Bob Streets, Resident; spoke against the trash fees.

Jennifer Strenstem; Resident; spoke about receiving a protest ballot after the County Assessors data was received.

Dave Atkinsons Resident; stated that since the second mailing of the supplemental post card extended the date of the Public Hearing, the new owners should have received a ballot.

MOTION by Council Member Brann, Seconded by Mayor Pro Tem Fisher to close the public hearing. MOTION PASSED BY UNANIMOUS VOICE VOTE: 5/0

City Attorney Mark Hensley briefly gave a history of Proposition 218 and what data would be used for the purpose of issuing protest ballots. He also stated that these guidelines were State requirements.

MOTION by Council Member Brann, SECONDED by Council Member Jacobson to dispense with the counting of the ballots and move forward to consider the protest sufficient and complete. The unopened and unverified Protest Ballots were deemed not a public record. MOTION PASSED BY THE FOLLOWING VOICE VOTE: AYES: BRANN, JACOBSON, FUENTES; NOES: BUSCH AND FISHER. 3/2

C. UNFINISHED BUSINESS

3. Consideration and possible action regarding adoption of the Resolutions updating the employer’s contribution under the Public Employees’ Medical and Hospital Care Act for the El Segundo Fire Fighters’ Association, the El Segundo Police Officers’ Association, the El Segundo City Employees’ Association, the El Segundo Police Support Services Association, and the El Segundo Supervisory and Professional Employees’ Association. Fiscal Impact: Active Employees: $31,600; Retirees $32,600.

Deborah Cullen, Finance Director, gave a report.

MOTION by Council Member Brann, SECONDED by Council Member Fuentes to adopt the following resolutions: El Segundo Fire Fighters’ Association, Resolution No. 4703, El Segundo Police Officers’ Association, Resolution No. 4704, El Segundo City Employees’ Association, Resolution No. 4705, El Segundo Police Support Services Association, Resolution No. 4706, and the El Segundo Supervisory and Professional Employees’ Association, Resolution No. 4707. MOTION PASSED BY UNANIMOUS VOICE VOTE 5/0
D. REPORTS OF COMMITTEES, COMMISSIONS AND BOARDS

E. CONSENT AGENDA

All items listed are to be adopted by one motion without discussion and passed unanimously. If a call for discussion of an item is made, the item(s) will be considered individually under the next heading of business.

4. Approved Warrant Numbers 2580178 to 2580365 on Register No. 6 in the total amount of $975,932.53 and Wire Transfers from 12/09/10 through 12/22/10 in the total amount of $1,624,953.38; and Warrant Numbers 2580564 to 2580727 on Register No. 7 in the total amount of $413,993.75 and Wire Transfers from 12/23/10 through 01/06/11 in the total amount of $619,616.42. Authorized staff to release. Ratified: Payroll and Employee Benefit checks; checks released early due to contracts or agreement; emergency disbursements and/or adjustments; and wire transfers.


6. Approved revised Class Specifications for the classifications of Police Officer Trainee and Construction Coordinator (At-Will). (Fiscal Impact: None)

7. Adopted Resolution No. 4702 approving a list of capital projects recommended for Measure R Highway Program funding and authorized the City Manager to execute all documents necessary for the administration of projects funded through Measure R. (Fiscal Impact: Approximately $4.4 million reimbursement of Measure R grant funds under Phase 1.)

8. Approved Agreement No. 4117 between the City of El Segundo, West Basin Municipal Water District (WBMWD), and El Segundo Energy Center (ESEC) for construction of a recycled water pipeline (RW) and a potable water pipeline (PW) for additional water services to ESEC. (Fiscal Impact: None) Authorized the City Manager to execute the agreement, in a form approved by the City Attorney, related to the design, permit, finance, and construction of the water pipelines by WBMWD for water services to ESEC.

9. Approved an updated list of pre-approved consultants that provide environmental review services pursuant to California Environmental Quality Act guidelines (CEQA) and National Environmental Policy Act (NEPA) regulations to assist the City in the processing of entitlement projects; and authorized the City Manager to execute Professional Services Agreements in an amount not to exceed $200,000 (increased from $125,000 currently), in a form approved by the City Attorney, for developer reimbursed environmental review services pursuant to CEQA and NEPA regulations from the pre-approved list of consultants. (Fiscal Impact: None)
10. Adopted Plans and Specifications for the 2010-2011 annual contract for curb, gutter, sidewalk and other minor improvements at various locations citywide. Approved Capital Improvement Program. Project No.: PW 11-01 (Fiscal Impact: $50,000 Gas Tax funds) Authorized staff to advertise the project for receipt of construction bids.

11. Approved the request from the El Segundo High School Band to allow banners to be hung over Main Street at no cost. (Fiscal Impact: $178)

12. Received proceeds from the sale of Fire Station #2. Net proceeds: $1,539,685.65. (Fiscal Impact: $1,539,685.65 Proceeds from Sale deposited to the Economic Uncertainty Fund.)

MOTION by Council Member Brann, SECONDED by Mayor Pro Tem Fisher to approve Consent Agenda Items 4, 5, 6, 7, 8, 9, 10, 11, and 12. MOTION PASSED BY UNANIMOUS VOICE VOTE. 5/0

CALL ITEMS FROM CONSENT AGENDA

F. NEW BUSINESS

G. REPORTS – CITY MANAGER – Debra Cullen, Finance Director gave a brief report on the impacts of the State Budget.

H. REPORTS – CITY ATTORNEY

I. REPORTS – CITY CLERK

13. Consideration and possible action regarding an initiative (the “Initiative”) amending the El Segundo Municipal Code to transfer all functions of the El Segundo Fire Department to the Consolidated Fire Protection District of Los Angeles County (aka the Los Angeles County Fire Department). (Fiscal Impact: Unknown)

Cindy Mortesen, City Clerk, gave a report.

MOTION by Council Member Brann, SECONDED by Mayor Busch, to defer this item to the February 15, 2011 City Council meeting, in order to receive a report on costs of elections and a report on the impacts of another initiative being circulated to cure any deficiencies that were in the first petition. MOTION PASSED BY UNANIMOUS VOICE VOTE. 5/0

J. REPORTS – CITY TREASURER

K. REPORTS – CITY COUNCIL MEMBERS
Council Member Fuentes – Reported that she recently attended a performance of the “Young Americans.”

Council Member Brann – Spoke regarding Candy Cane Lane and the Holiday Parade. He also spoke on the Green Line extension.

Council Member Jacobson – NONE

Mayor Pro Tem Fisher – Reflected on 2010.

Mayor Busch –

Announcement of retirees for 2010:

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Date Range</th>
<th>Years</th>
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</thead>
<tbody>
<tr>
<td>Mayor</td>
<td>Hobart (Kelly) McDowell</td>
<td>4/21/98 - 04/20/2010</td>
<td>12 yrs</td>
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<tr>
<td>Asst. City Manager</td>
<td>Bill Crowe</td>
<td>2/22/06 - 12/31/2010</td>
<td>4.75 yrs</td>
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<td>Fire</td>
<td>John Bibe</td>
<td>2/15/75 - 12/21/2010</td>
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<td>Betsy Kozykoski</td>
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<td>Information Services</td>
<td>Norm Thorn</td>
<td>4/25/05 - 12/31/2010</td>
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<tr>
<td>Library</td>
<td>Elisa Bonilla</td>
<td>2/28/94 - 12/18/2010</td>
<td>16.8 yrs</td>
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<tr>
<td>Plan. &amp; Bldg. Safety</td>
<td>Evelyn Gossett</td>
<td>4/19/95 - 01/15/2010</td>
<td>14.7 yrs</td>
</tr>
<tr>
<td>Plan. &amp; Bldg. Safety</td>
<td>Mary Lewis</td>
<td>2/29/97 - 12/31/2010</td>
<td>13 yrs</td>
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<tr>
<td>Police</td>
<td>Walter Krumbach</td>
<td>11/13/79 - 05/07/2010</td>
<td>30.5 yrs</td>
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<tr>
<td>Police</td>
<td>Yvonne Redford</td>
<td>2/25/80 - 08/30/2010</td>
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<td>Police</td>
<td>Christine Vukelich</td>
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<td>Police</td>
<td>Roger Stephenson</td>
<td>9/8/81 - 12/21/2010</td>
<td>29.3 yrs</td>
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<td>Police</td>
<td>Michael Mitchell</td>
<td>8/10/92 - 12/31/2010</td>
<td>17.4 yrs</td>
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<tr>
<td>Police</td>
<td>Jan Mitsuda</td>
<td>3/13/85 - 12/31/2010</td>
<td>25.8 yrs</td>
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Announced free airplane rides sponsored by the Experimental Aircraft Association, at Hawthorne Airport, January 29, 2011, to the first 60 applications.

PUBLIC COMMUNICATIONS – (Related to City Business Only – 5 minute limit per person, 30 minute limit total) Individuals who have receive value of $50 or more to communicate to the City Council on behalf of another, and employees speaking on behalf of their employer, must so identify themselves prior to addressing the City Council. Failure to do so shall be a misdemeanor and punishable by a fine of $250. While all comments are welcome, the Brown Act does not allow Council to take action on any item not on the agenda. The Council will respond to comments after Public Communications is closed.

Mike Robbins, Resident; thanked Council Members who deemed the protest ballots sufficient and withdrew the proposed trash fee. Requested case numbers referred to which deal with petition circulators.
Mark Rener, Resident; spoke regarding the budget problems.

ADJOURNMENT: 9:26 P.M.

______________________________
Cindy Mortesen, City Clerk
AGENDA DESCRIPTION:

Consideration and possible action regarding acceptance of the project for the rehabilitation of Grand Avenue from Sepulveda Boulevard to Duley Road. Project No.: PW 10-03 (Fiscal Impact: $338,365.52)

RECOMMENDED COUNCIL ACTION:

1. Accept the work as complete.
2. Authorized the City Clerk to file a Notice of Completion in the County Recorder's Office.
3. Alternatively, discuss and take other action related to this item.

ATTACHED SUPPORTING DOCUMENTS:

Notice of Completion

FISCAL IMPACT: Included in Adopted Budget

Amount Requested: $0
Additional Appropriation: No
Account Number(s): 106-400-8203-8986

ORIGINATED BY: Maryam M. Jonas, Principal Engineer
REVIEWED BY: Stephanie Katsouleas, Public Works Director
APPROVED BY: Jack Wayt, City Manager

BACKGROUND AND DISCUSSION:

On September 21, 2010 the City entered into a public works contract with Silvia Construction, Inc. in the amount of $345,873.70 for the pavement rehabilitation of Grand Avenue between Sepulveda Boulevard and Duley Road. The Council also approved an additional $19,126.30 to cover construction contingencies.

Construction began on November 1, 2010 and was completed in accordance with the plans and specifications on December 14, 2010. The total construction cost, based on measured quantities, is $338,365.52 and is fully funded through an allocation from State Proposition 1B. Grant. Staff recommends the City Council accept as complete the work performed by Silvia Construction Inc.
NOTICE OF COMPLETION OF CONSTRUCTION PROJECT

Project Name: Grand Avenue Pavement Rehabilitation
Project No.: PW 10-03

Notice is hereby given pursuant to State of California Civil Code Section 3093 et seq that:

1. The undersigned is an officer of the owner of the interest stated below in the property hereinafter described.
2. The full name of the owner is: City of El Segundo
3. The full address of the owner is: City Hall, 350 Main Street, El Segundo, CA, 90245
4. The nature of the interest of the owner is: Public Street Improvements
5. A work of improvement on the property hereinafter described was field reviewed by the City Engineer on December 21, 2010. The work done was: Pavement Rehabilitation of Grand Avenue
6. On February 1, 2011, City Council of the City of El Segundo accepted the work of this contract as being complete and directed the recording of this Notice of Completion in the Office of the County Recorder.
7. The name of the Contractor for such work of improvement was: Sitvia Construction, Inc.,
8. The property on which said work of improvement was completed is in the City of El Segundo, County of Los Angeles, State of California, and is described as follows: Public Street
9. The street address of said property is: Grand Avenue between Sepulveda Boulevard and Duley Road.

Dated: ________________________________

Stephanie Katsouleas
Public Works Director

VERIFICATION

I, the undersigned, say: I am the Director of Public Works/City Engineer of the City El Segundo, the declarant of the foregoing Notice of Completion; I have read said Notice of Completion and know the contents thereof; the same is true of my own knowledge.

I declare under penalty of perjury the foregoing is true and correct.

Executed on _________________, 2011 at El Segundo, California.

Stephanie Katsouleas
Public Works Director
AGENDA DESCRIPTION:
Consideration and possible action regarding the acceptance of $39,810 in grant funding from the U.S. Department of Homeland Security, through the Office of Grants and Training, under Fiscal Year 2008 and 2009 State Homeland Security Grant Programs (SHSGP) to pursue regional training and radio programming.  
(Fiscal Impact: $39,810)

RECOMMENDED COUNCIL ACTION:
1. Authorize the acceptance of $39,810 in grant funds from the SHSGP 2008 and SHSGP 2009 grant programs;
2. Authorize the City Manager to sign Agreements with the County of Los Angeles who will serve as grant administrator for both grants;
3. Alternatively, discuss and take other action related to this item.

ATTACHED SUPPORTING DOCUMENTS:
None

FISCAL IMPACT: Budget Adjustment Required

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<td>Additional Appropriation:</td>
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<td>124-400-3765-6223 Expenditure, Training $34,110</td>
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ORIGINATED BY: Lisa LeCates, Sr. Management Analyst

REVIEWED BY: Kevin S. Smith, Fire Chief

APPROVED BY: Jack Wayt, City Manager

BACKGROUND AND DISCUSSION:
The City of El Segundo has been allocated $39,810 in State Homeland Security Grant Program (SHSGP) funding, as part of a regional effort to provide radio programming and regional training. Both grants are funded through the U.S. Department of Homeland Security, which is then passed through the California Office of Emergency Management (CalEMA), and then to the local area through the County of Los Angeles.

Under the SHSGP 2008 program, the City was awarded $5,700 to program its existing radio equipment to comply with the Federal Communications Commission’s (FCC) requirement regarding radio frequencies. The FCC’s mandate essentially requires all existing radio frequencies be split into two, which is more commonly known as “Narrowbanding”. The SHSGP 2008 grant award will assist with the cost of programming the Fire Department’s portable and mobile radio equipment.
The SHSGP 2009 grant provides $34,110 in funding for two training programs: 1) Chemical, Biological, Radiological, Nuclear, and Explosives (CBRNE); and 2) Terrorism Liaison Officer (TLO), as part of a regional program to train all Los Angeles area fire departments to the same standard.

**In accordance with the City Council Policy regarding grant submissions:**

1. The grant award is made by the U.S. Department of Homeland Security, through the Office of Grants and Training. The grant is administered by the County of Los Angeles and is overseen by the CalEMA.
2. The total amount being requested is: $5,700 (SHSGP 2008) and $34,110 (SHSGP 2009)
3. Matching Funds Cost-Share – n/a
4. Source of Matching Funds Cost Share: n/a
5. The grant does not provide up front funding. Municipalities submit reimbursement requests to the grant administrator after expenditures are made and processed for payment. Approved requests are reimbursed by the County of Los Angeles.
AGENDA DESCRIPTION:

Consideration and possible action to adopt Ordinance No. 1458 approving Environmental Assessment EA 881, Specific Plan Amendment No. 10-01, and Zone Text Amendment ZTA 10-04 to amend the Smoky Hollow Specific Plan Land Use Plan and the El Segundo Municipal Code ("ESMC") regulating the permitted uses in the Small Business (SB) and Medium Manufacturing (MM) Zones (Fiscal Impact: N/A)

RECOMMENDED COUNCIL ACTION:

1. Waive second reading and adopt Ordinance No. 1458 for Environmental Assessment EA 881, Specific Plan Amendment No. 10-01, and Zone Text Amendment ZTA 10-04; and/or
2. Alternatively, discuss and take other possible action related to this item.

ATTACHED SUPPORTING DOCUMENTS:

1. Ordinance No. 1458

FISCAL IMPACT: None

Amount Budgeted: N/A
Additional Appropriation: N/A
Account Number(s): N/A

ORIGINATED BY: Kimberly Christensen, AICP, Planning Manager
REVIEWED BY: Greg Carpenter, Director of Planning and Building Safety
APPROVED BY: Jack Wayt, City Manager

BACKGROUND AND DISCUSSION:

I. Background

On January 18, 2011, the City Council introduced an Ordinance to approve Environmental Assessment EA 881, Specific Plan Amendment No. 10-01, and Zone Text Amendment ZTA 10-04 to amend the Smoky Hollow Specific Plan and the permitted uses in the Small Business (SB) and Medium Manufacturing (MM) Zones. The Council may waive second reading and adopt the Ordinance. If adopted without change, Ordinance No. 1458 will become effective in 30 days.
ORDINANCE NO. 1458

AN ORDINANCE APPROVING A SPECIFIC PLAN AMENDMENT AND A ZONE TEXT AMENDMENT TO AMEND THE SMOKY HOLLOW SPECIFIC PLAN AND THE PERMITTED USES IN THE SMALL BUSINESS (SB) AND MEDIUM MANUFACTURING (MM) ZONES TO ALLOW ART STUDIOS AND A WIDER RANGE OF OFFICE USES.

The City Council of the city of El Segundo does ordain as follows:

SECTION 1: The City Council incorporates by reference all of the findings and conclusions set forth in Planning Commission Resolution No. 2684 as if fully set forth.

SECTION 2: Environmental Assessment. The City Council certifies the Negative Declaration of Environmental Impacts proposed for this project pursuant to CEQA Guidelines §15070. A Notice of Intent to Adopt a Negative Declaration was prepared pursuant to CEQA Guidelines §§ 15072 and 15073 and was available for public comment from November 5, 2010 to December 6, 2010.

SECTION 3: El Segundo Municipal Code ("ESMC") § 15-11-2(E)(1)(a) is amended to read as follows:

"Small Business Area: This district covers the portion of the Specific Plan area from Standard Street to the alley east of Lomita Street. The area is characterized by smaller or incubator industrial and manufacturing uses located on small parcels, many without off-street parking. It is an area in which small "incubator" business concerns exist and many continue to flourish. Presently, one hundred twelve (112) various parcels exist in the area. Seventy eight (78) of the parcels, seventy percent (70%) of the existing parcels, are under ten thousand (10,000) square feet in size, many are under five thousand (5,000) square feet. The desire is to maintain a small industrial business environment, but not to preclude lot consolidation, business expansion and growth. Design guidelines will allow some flexibility to achieve visual enhancement of the area. The small business area is a transition between the pedestrian scale downtown and the medium sized manufacturing area to the east. Uses will basically remain the same as at present, with an emphasis on the smaller industrial user and limited general and multimedia related office space."

SECTION 4: ESMC § 15-6C-1 is amended to read as follows:

"PURPOSE: The purpose of this zone is to perpetuate the existence of the small business and incubator industrial user in the Smoky Hollow area. As such, this zone is to be utilized only within the boundaries of the Smoky Hollow specific plan. It is recognized that the areas that provide small businesses a place to establish and prosper are becoming more and more scarce and at the same time becoming
increasingly desirable. This unique environment is felt to be an appropriate location for light industrial activities, research, and technological processes, restaurants, cafeterias and offices. It is also the purpose of this zone to allow maximum site development flexibility in return for well conceived and efficient site planning and landscaping to complement the good development which presently exists in the area.”

SECTION 5: ESMC § 15-6C-2 is amended to read as follows:

"PERMITTED USES: The following uses are permitted in the SB zone:

A. Art studios (Production space only).

B. General offices in conjunction with any other permitted use as long as the office use does not occupy in excess of forty percent (40%) of the total building square footage.

C. General and/or multimedia related offices, up to fifteen thousand (15,000) square feet per site.

D. Light industrial uses.

E. Manufacturing.

F. Public facilities and utilities.

G. Research and development.

H. Restaurants and cafes without drive-through facilities.

I. Warehousing and distribution.

J. Other similar uses approved by the Director of Planning and Building Safety, as provided by chapter 22 of this title."

SECTION 6: ESMC § 15-6D-1 is amended to read as follows:

"PURPOSE: The purpose of this zone is to provide a transitional land use area between the high intensity aircraft/aerospace office uses east of Sepulveda Boulevard and the small single parcel industrial businesses of the westerly portion of the Smoky Hollow area. As such, the zone is to be utilized only within the boundaries of the Smoky Hollow specific plan. This zone provides for the continuation and development of medium size light industrial, manufacturing, and limited office activities.”

SECTION 7: ESMC § 15-6D-2 is amended to read as follows:
"PERMITTED USES: The following uses are permitted in the MM zone:

A. Art studios (Production space only).

B. General offices in conjunction with any other permitted use as long as the office does not occupy in excess of sixty percent (60%) of the total building square footage.

C. General and/or multimedia related offices, up to fifteen thousand (15,000) square feet per site, except for mixed use projects of 30,000 square feet or more, in which the size may be greater.

D. Light assembly and processing.

E. Light industrial.

F. Manufacturing.

G. Mixed use projects including commercial, office and light industrial uses. In mixed use projects of 30,000 square feet or more where the light industrial uses make up at least fifty percent (50%) of the total project’s square footage.

H. Parking structures and parking lots.

I. Public facilities, public utilities.

J. Research and development.

K. Restaurants and cafes without drive-through facilities.

L. Retail sales for wholesale outlets.

M. Warehousing and distribution.

N. Other similar uses approved by the Director of Planning and Building Safety, as provided by chapter 22 of this title."

SECTION 8: CONSTRUCTION. This Ordinance must be broadly construed in order to achieve the purposes stated in this Ordinance. It is the City Council’s intent that the provisions of this Ordinance be interpreted or implemented by the City and others in a manner that facilitates the purposes set forth in this Ordinance.

SECTION 9: ENFORCEABILITY. Repeal of any provision of the ESMC does not affect any penalty, forfeiture, or liability incurred before, or preclude prosecution and imposition of penalties for any violation occurring before this Ordinance’s effective date.
Any such repealed part will remain in full force and effect for sustaining action or prosecuting violations occurring before the effective date of this Ordinance.

SECTION 10: VALIDITY OF PREVIOUS CODE SECTIONS. If this entire Ordinance or its application is deemed invalid by a court of competent jurisdiction, any repeal or amendment of the ESMC or other city ordinance by this Ordinance will be rendered void and cause such previous ESMC provision or other the city ordinance to remain in full force and effect for all purposes.

SECTION 11: If any part of this Ordinance or its application is deemed invalid by a court of competent jurisdiction, the city council intends that such invalidity will not affect the effectiveness of the remaining provisions or applications and, to this end, the provisions of this Ordinance are severable.

SECTION 12: The City Clerk is directed to certify the passage and adoption of this Ordinance; cause it to be entered into the City of El Segundo’s book of original ordinances; make a note of the passage and adoption in the records of this meeting; and, within fifteen (15) days after the passage and adoption of this Ordinance, cause it to be published or posted in accordance with California law.

SECTION 13: This Ordinance will remain effective until superseded by a subsequent ordinance.
SECTION 14: This Ordinance will become effective on the thirty-first (31st) day following its passage and adoption.

PASSED AND ADOPTED this ___ day of __________, 2011.

_________________________________________
Eric Busch, Mayor

ATTEST:

STATE OF CALIFORNIA   )
COUNTY OF LOS ANGELES )   SS
CITY OF EL SEGUNDO   )

I, Cindy Mortesen, City Clerk of the City of El Segundo, California, do hereby certify that the whole number of members of the City Council of said City is five; that the foregoing Ordinance No. 1458 was duly introduced by said City Council at a regular meeting held on the 18th day of January, 2011, and was duly passed and adopted by said City Council, approved and signed by the Mayor, and attested to by the City Clerk, all at a regular meeting of said Council held on the 1st day of February, 2011, and the same was so passed and adopted by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

______________________________
Cindy Mortesen, City Clerk

APPROVED AS TO FORM:
Mark D. Hensley, City Attorney

By: ______________________________________
Karl H. Berger, Assistant City Attorney
AGENDA DESCRIPTION:
Consideration and possible action regarding approval of a Resolution amending the City’s Flexible Benefits Plan Document and Summary Plan Description to reflect changes resulting from the Affordable Care Act of 2010 eliminating the reimbursement of over-the-counter medicine or drugs from the health spending account. Fiscal Impact: None

RECOMMENDED COUNCIL ACTION:
1. Adopt the Resolution
2. Alternatively, discuss and take other action related to this item.

ATTACHED SUPPORTING DOCUMENTS:
1. Proposed Resolution
2. Amended Plan Document (Exhibit A)
3. Amended Summary Plan Description (Exhibit B)

FISCAL IMPACT: N/A
   Amount Budgeted: N/A
   Additional Appropriation: 
   Account Number(s):

ORIGINATED BY: Martha A. Dijkstra, Human Resources Manager
REVIEWED BY: Deborah Cullen, Director of Finance
APPROVED BY: Jack Wayt, City Manager

BACKGROUND AND DISCUSSION:
HealthComp currently administers the City’s Flexible Benefits Plan (the “Plan”). This Plan is designed to permit eligible employees to pay their share of premiums under the City’s health insurance plan, and to contribute to an account for reimbursement of certain medical care expenses and dependent care expenses all on a pre-tax basis.

The Affordable Care Act of 2010 (“Act”) created new limits to this Plan. Specifically, effective January 1, 2011, the cost of an over-the-counter (OTC) medicine or drug will no longer be reimbursed from a health spending account unless prescribed by a doctor. In other words, this Act has reduced the list of allowable medical expenses that may be reimbursed.

In order to bring the City’s Plan into compliance with the Act and ensure the Plan continues to qualify under applicable provisions of the Internal Revenue Code, HealthComp is requiring the City to amend the Plan Document and Summary Plan Description and, for the first time, is requiring an approved Resolution.
RESOLUTION NO.  

A RESOLUTION AMENDING THE CITY OF EL SEGUNDO'S FLEXIBLE BENEFITS PLAN

The City Council of the City of El Segundo does resolve as follows:

Section 1: The form of amended Cafeteria Plan including a Dependent Care Flexible Spending Account and Health Flexible Spending Account effective January 1, 2011, (Exhibit A) is approved and adopted. The City Manager, or designee is authorized and directed to execute and deliver to the Plan Administrator one or more counterparts of the Plan.

Section 2: The Administrator is instructed to take such actions that are necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

Section 3: The City Manager, or designee, is directed to act as soon as possible to notify the employees of the City of El Segundo of the adoption of the Cafeteria Plan by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description (Exhibit B).

Section 4: Exhibits A and B of this Resolution are true copies of the City of El Segundo Flexible Benefits Plan as amended and restated and the Summary Plan Description approved and adopted in this Resolution.

Section 5: The City Clerk is directed to certify the Passage and Adoption of this Resolution, enter same in the Book of Original Resolutions, and make a Minute of its adoption in the City’s records and in the Minutes of the meeting when it was adopted.

Section 6: The Resolution will become effective immediately upon adoption, and will remain effective unless repealed or superseded.

PASSED AND ADOPTED this 1st day of February, 2011.

______________________________  
Eric K. Busch,  
Mayor
CERTIFICATION

STATE OF CALIFORNIA )
COUNTY OF LOS ANGELES ) SS
CITY OF EL SEGUNDO )

I, Cindy Mortesen, City Clerk of the City of El Segundo, California, do hereby certify that the whole number of members of the City Council of said City is five; that the foregoing Resolution No. _____ was duly passed and adopted by said City Council, approved and signed by the Mayor, and attested to by the City Clerk, all at a regular meeting of said Council held on the 1st day of February, 2011, and the same was so passed and adopted by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

NOT PARTICIPATING:

WITNESS MY HAND THE OFFICIAL SEAL OF SAID CITY this _____ day of ____________, 2011.

Cindy Mortesen, City Clerk
of the City of El Segundo,
California
(SEAL)

APPROVED AS TO FORM:
Mark D. Hensley, City Attorney

By: Karl H. Berger
Assistant City Attorney
EXHIBIT "A"

CITY OF EL SEGUNDO FLEXIBLE BENEFITS PLAN
AND ALL SUPPORTING FORMS HAVE BEEN PRODUCED FOR
CITY OF EL SEGUNDO

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CITY OF EL SEGUNDO FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2011, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on March 1, 1989. The Plan shall be known as City of El Segundo Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 "Affiliated Employer" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "Benefit" or "Benefit Options" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "Cafeteria Plan Benefit Dollars" means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 "Compensation" means the amounts received by the Participant from the Employer during a Plan Year.
1.7 "Dependent" means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, as allowed by reason of the Affordable Care Act.

1.8 "Effective Date" means March 1, 1989.

1.9 "Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 "Eligible Employee" means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

However, any Employee who is a "part-time" Employee shall not be eligible to participate in this Plan. A "part-time" Employee is any Employee who works, or is expected to work on a regular basis, less than 20 hours a week and is designated as a part-time Employee on the Employer's personnel records.

1.11 "Employee" means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 "Employer" means City of El Segundo and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 "Grace Period" means, with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year, during which Medical Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year.

1.14 "Insurance Contract" means any contract issued by an Insurer underwriting a Benefit.

1.15 "Insurance Premium Payment Plan" means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.16 "Insurer" means any insurance company that underwrites a Benefit under this Plan.
1.17 "Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 "Participant" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 "Plan" means this instrument, including all amendments thereto.

1.20 "Plan Year" means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 "Premium Expenses" or "Premiums" mean the Participant's cost for the Benefits described in Section 4.1.

1.22 "Premium Expense Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 "Spouse" means "spouse" as defined in an Insurance Contract for purposes of coverage under that Contract only or the legally married husband or wife of a Participant, unless legally separated by court decree.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder 30 days after his initial date of employment with the Employer. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.
2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of
the month coinciding with or next following the date on which he met the eligibility
requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable
Election Period, complete an application to participate and election of benefits form which the
Administrator shall furnish to the Employee. The election made on such form shall be
irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change
his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection
Agreement during the Election Period for the Plan Year during which he wishes to participate in
this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period
beginning on or after the Employée's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of
the following events:

(a) Termination of employment. The Participant's termination of
employment, subject to the provisions of Section 2.6;

(b) Change in employment status. The end of the Plan Year during
which the Participant became a limited Participant because of a change in
employment status pursuant to Section 2.5;

(c) Death. The Participant's death, subject to the provisions of Section
2.7; or

(d) Termination of the plan. The termination of this Plan, subject to
the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in
employment status or classification (other than through termination of employment), the
Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in
which such change of employment status occurs. As a limited Participant, no further Salary
Redirection may be made on behalf of the Participant, and, except as otherwise provided herein,
all further Benefit elections shall cease, subject to the limited Participant's right to continue
coverage under any Insurance Contracts. However, any balances in the limited Participant's
Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the
limited Participant for any allowable Employment-Related Dependent Care incurred during the
Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an

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Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.7 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.
ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.
ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account
(2) Dependent Care Flexible Spending Account
(3) Insurance Premium Payment Plan
(i) Health Insurance Benefit
(ii) Dental Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) Coverage for Participant and Dependents. Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) Employer selects contracts. The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
(b) Employer selects contracts. The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) 25% concentration test. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.
ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS

(a) Change in status defined. Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.
In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

(b) Special enrollment rights. Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) Qualified Medical Support Order. Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) Medicare or Medicaid. Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.
(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent
care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) Health FSA cannot change due to insurance change. A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) "Health Flexible Spending Account" means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
(c) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

Effective January 1, 2011, including amounts related to the Grace Period for the 2010 Plan Year, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $Unlimited.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the
Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) Expenses must be incurred during Plan Year. All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year including the Grace Period shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) Reimbursement available throughout Plan Year. The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Payments. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for
payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Grace Period.** Notwithstanding anything in this Section to the contrary, Medical Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates.

(e) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. Non-prescription drug costs incurred during the Grace Period related to the 2010 Plan Year shall not be reimbursed.

6.8 **QUALIFIED RESERVIST DISTRIBUTIONS**

(a) **Qualified Reservist Distribution.** A Participant may request a Qualified Reservist Distribution, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if:

(1) Such Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.

(2) A Participant may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with subsection (a).

(3) The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year (or Grace Period) which includes the date of such order or call.

(4) The Qualified Reservist Distribution option is offered to all Participants who qualify under this Article.

(5) Qualified Reservist Distributions may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.
(6) Under Section 101 of the Title 37 of the United States Code, "reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.

(b) **Conditions:** The following conditions apply:

(1) The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty.

(2) Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.

(3) If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.

(c) **Amount:** The amount a Participant may be reimbursed from the Health Flexible Spending Account is the amount contributed by the Participant to the Health Flexible Spending Account as of the date of the distribution request, less any reimbursements received as of the date of the distribution request.

(d) **Procedure.** The Employer must specify a process for requesting the distribution. The Employer may limit the number of distributions processed for a Participant to one per Plan Year. The distribution request must be made on or after the call or order and before the last day of the Grace Period. The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.

(e) **Claims.** Claims incurred prior to the date of the request of the distribution shall be paid as any other claim. Claims incurred after the date of the distribution shall be paid on submission as any other claim.

**ARTICLE VII**

**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

**7.1 ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.
7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) "Dependent Care Flexible Spending Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.
(d) "Qualifying Dependent" means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.
7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) Code limits. Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) 25% test for shareholders. It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the
amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) Claims for reimbursement. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Insurance claims. Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.
(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

1. specific references to the pertinent Plan provisions on which the denial is based;

2. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

3. an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

1. request a review upon written notice to the Administrator;

2. review pertinent documents; and

3. submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if applicable) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been
denied is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan.
Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

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

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.
9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously 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 any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.
ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT’S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER’S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant’s Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in
question and the actual insurance proceeds, if any, received by the Employer or
the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be
responsible for the validity of any Insurance Contract issued hereunder or for the
failure on the part of the Insurer to make payments provided for under any
Insurance Contract. Once insurance is applied for or obtained, the Employer shall
not be liable for any loss which may result from the failure to pay Premiums to
the extent Premium notices are not received by the Employer.

11.8 **NO GUARANTEE OF TAX CONSEQUENCES**

Neither the Administrator nor the Employer makes any commitment or guarantee
that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from
the Participant's gross income for federal or state income tax purposes, or that any other federal
or state tax treatment will apply to or be available to any Participant. It shall be the obligation of
each Participant to determine whether each payment under the Plan is excludable from the
Participant's gross income for federal and state income tax purposes, and to notify the Employer
if the Participant has reason to believe that any such payment is not so excludable.
Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally
enforceable.

11.9 **INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

If any Participant receives one or more payments or reimbursements under the
Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the
Employer for any liability it may incur for failure to withhold federal or state income tax or
Social Security tax from such payments or reimbursements. However, such indemnification and
reimbursement shall not exceed the amount of additional federal and state income tax (plus any
penalties) that the Participant would have owed if the payments or reimbursements had been
made to the Participant as regular cash compensation, plus the Participant's share of any Social
Security tax that would have been paid on such compensation, less any such additional income
and Social Security tax actually paid by the Participant.

11.10 **FUNDING**

Unless otherwise required by law, contributions to the Plan need not be placed in
trust or dedicated to a specific Benefit, but may instead be considered general assets of the
Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed
to require the Employer or the Administrator to maintain any fund or segregate any amount for
the benefit of any Participant, and 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.
11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.
11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
(ii) appropriate sanctions against the persons causing the
breach which, depending upon the nature of the breach, may
include oral or written reprimand, additional training, or
termination of employment;

(iii) mitigation of any harm caused by the breach, to the
extent practicable; and

(iv) documentation of the incident and all actions taken to
resolve the issue and mitigate any damages.

(e) Certification. The Employer must provide certification to the Plan
that it agrees to:

(1) Not use or further disclose the information other than as permitted
or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides
Protected Health Information received from the Plan, agrees to the same
restrictions and conditions that apply to the Employer with respect to such
information;

(3) Not use or disclose Protected Health Information for employment-
related actions and decisions or in connection with any other benefit or
employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health
Information of which it becomes aware that is inconsistent with the uses or
disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan
members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by
individual Plan members and incorporate any amendments to Protected
Health Information in accordance with Section 164.526 of the Privacy
Standards;

(7) Make available the Protected Health Information required to
provide an accounting of disclosures to individual Plan members in
accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use
and disclosure of Protected Health Information received from the Plan
available to the Department of Health and Human Services for purposes of
determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information
received from the Plan that the Employer still maintains in any form, and
retain no copies of such information when no longer needed for the
purpose for which disclosure was made, except that, if such return or
destruction is not feasible, limit further uses and disclosures to those
purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of
the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the
Privacy Standards and set out in (d) above.

11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health
Information (45 CFR Part 164.300 et. seq., the "Security Standards"):  

(a) Implementation. The Employer agrees to implement reasonable
and appropriate administrative, physical and technical safeguards to protect the
confidentiality, integrity and availability of Electronic Protected Health
Information that the Employer creates, maintains or transmits on behalf of the
Plan. "Electronic Protected Health Information" shall have the same definition as
set out in the Security Standards, but generally shall mean Protected Health
Information that is transmitted by or maintained in electronic media.

(b) Agents or subcontractors shall meet security standards. The
Employer shall ensure that any agent or subcontractor to whom it provides
Electronic Protected Health Information shall agree, in writing, to implement
reasonable and appropriate security measures to protect the Electronic Protected
Health Information.

(c) Employer shall ensure security standards. The Employer shall
ensure that reasonable and appropriate security measures are implemented to
comply with the conditions and requirements set forth in Section 11.18.

11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the
Mental Health Parity and Addiction Equity Act and ERISA Section 712.

11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the
Genetic Information Nondiscrimination Act.

11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the
11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.
IN WITNESS WHEREOF, this Plan document is hereby executed this 
________ day of ____________________.

City of El Segundo

By ______________________
EMPLOYER
EXHIBIT "B"

CITY OF EL SEGUNDO FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION
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XI

SUMMARY
CITY OF EL SEGUNDO FLEXIBLE BENEFITS PLAN

INTRODUCTION

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

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

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

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

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

I

ELIGIBILITY

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

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

You will be eligible to join the Plan once you have completed 30 days of employment. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

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

4. Are there any employees who are not eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are part-time. A part-time employee is someone who works, or is expected to work, less than 20 hours a week.

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

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

II
OPERATION

1. How does this Plan operate?

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

III
CONTRIBUTIONS

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

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

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

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

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

4. **When is the election period for our Plan?**

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

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

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

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

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

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

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

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.
In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

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

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

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

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

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

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

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

**IV

BENEFITS

1. **What benefits are offered under the Plan?**

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year.
2. **Health Flexible Spending Account**

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by insurance and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed. Beginning January 1, 2011, you may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. If you incur "over the counter" drug costs during the Grace Period, you may not be reimbursed for those amounts, only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

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

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

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

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

3. **Dependent Care Flexible Spending Account**

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

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

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

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

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

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

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

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

4. **Premium Expense Account**

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

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

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

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

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

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

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

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

If you have not spent all the amounts in your Health Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Health Flexible Spending Account.

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

3. **Family and Medical Leave Act (FMLA)**

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

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

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

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

5. **What happens if I terminate employment?**

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

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

   (b) You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.
(c) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. **Will my Social Security benefits be affected?**

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

7. **Qualified Reservist Distributions**

If you are a member of a reserve unit and if you are ordered or called to active duty, then you may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in your Health Flexible Spending Account. You can only request this distribution if you are called to active duty for a period of 180 days or more or for an indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the call.

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

**VI**

**HIGHLY COMPENSATED AND KEY EMPLOYEES**

1. **Do limitations apply to highly compensated employees?**

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

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

VII
PLAN ACCOUNTING

1. Periodic Statements

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

VIII
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

City of El Segundo Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your amended Plan become effective on January 1, 2011. Your Plan was originally effective on March 1, 1989.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

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

City of El Segundo
350 Main Street
El Segundo, California 90245
95-6000706
3. Plan Administrator Information

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

City of El Segundo
350 Main Street
El Segundo, California 90245
310 524-2336

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

4. Service of Legal Process

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

City of El Segundo
350 Main Street
El Segundo, California 90245

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

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

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

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

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

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

X

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).
2. **Who can become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

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

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

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

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

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

3. **What is a Qualifying Event?**

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

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

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

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

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

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

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

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

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

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

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

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/taact.

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

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

(a) the end of employment or reduction of hours of employment,
(b) death of the employee,

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

(d) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

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

City of El Segundo
350 Main Street
El Segundo, California 90245

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

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

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

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

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation

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coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

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

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

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

(a) The last day of the applicable maximum coverage period.
(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
(e) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

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

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

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

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

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

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

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

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

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

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

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

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

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

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

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

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

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

Yes. The Plan is also permitted to allow for payment at other intervals.
16. **What is Timely Payment for COBRA continuation coverage?**

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

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

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

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

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

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

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

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

XI
SUMMARY

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

If you have any questions, please contact the Administrator.
AGENDA DESCRIPTION:

Consideration and possible action to (1) determine which residential properties will receive City-provided trash collection services when the City’s current residential trash collection contract expires on July 31, 2011; (2) approve the Trash Subcommittee’s recommendation to bid out the contract for trash collection services and select one of the Subcommittee’s bidding options for a new trash collection contract to begin August 1, 2011. (Fiscal Impact: Unknown; fiscal impact to the City estimated at $444,906 to $561,000 depending on City Council Action(s) taken on this agenda item.)

RECOMMENDED COUNCIL ACTION:

1. Direct staff to either include or exclude City-provided trash service for three and four unit properties in the next residential trash hauling contract.

2. Approve the Trash Subcommittee’s recommendation to bid out the contract for trash collection services and select one of the bidding options developed by the Subcommittee for a new trash collection contract to begin August 1, 2011.

3. Alternatively, take other action related to this item.

ATTACHED SUPPORTING DOCUMENTS:

FISCAL IMPACT: To Be Determined.

Amount Budgeted: $  
Additional Appropriation: N/A  
Account Number(s):

ORIGINATED BY: Stephanie Katsouleas, Director of Public Works
REVIEWED BY: Mark Hensley, City Attorney
APPROVED BY: Jack Wayt, City Manager

BACKGROUND AND DISCUSSION:

Current Trash Hauling Services
The City has, since 1993, contracted its residential and city waste hauling services with Consolidated Disposal Service (Consolidated). The original contract was initiated in 1993 with three multi-year extensions approved over the past 18 years (1998, 2001 and 2006). Other contract modifications and amendments were also approved by City Council at various times throughout Consolidated’s tenure (e.g., green waste collection, recycling). Consolidated’s current contract identifies a 3-year contract extension option. A brief overview of the services currently provided by Consolidated is provided below.
Consideration of Inclusion or Exclusion of Residential Properties Greater Than Two (2) Units

It is estimated that El Segundo provides trash collection services to 4163 residential properties,\(^1\) which include not only single family homes but also duplexes and three and four unit complexes. El Segundo’s Municipal Code (ESMC) §5-2-2 requires that the shall City provide and residential dwelling units are required to use the City-provided waste hauling service, stating in part,

A. Collection by City: The City shall collect and dispose of residential and miscellaneous refuse from every residential unit within the City at least once per week; provided, that such refuse is prepared and placed for collection in accordance with the provisions of this Chapter and of subsequent resolutions that may be adopted from time to time by the City Council.

B. Residential Dwelling Units: All occupants of residential dwelling units shall be required to use the refuse service provided by the City. “Residential dwelling units” as used herein means single-family and two-family unit residences, not including condominiums or stock-cooperatives.”

While the City is only required to collect waste from one (1) and two (2) unit properties, it has historically also provided trash collection services to properties with more than two units (the most common being three and four unit properties). The average cost to the City to provide waste hauling service to each property is calculated at $11.55 and derived using the City’s 3162 1-4 unit parcels containing a total of 4163 service addresses). Correspondingly, staff estimates that the City spends approximately $444,906 providing collection services to 2876 qualifying single family/duplex properties and an additional $132,294 for the 265 multi-family properties not covered by ESMC 5-2-2. Should City Council decide to discontinue service to multi-family parcels greater than two (2) units, it would likely realize savings over the current contract rate. However, the actual cost savings realized would depend on the new, negotiated rate obtained in the next waste hauling contract.

Staff recommends that City Council direct staff on whether to either include or exclude three (3) and four (4) unit properties prior to bidding or renegotiating its next residential trash collection contract. If Council determines that the City will no longer provide service to three (3) and four (4) unit properties, then staff will notify these properties that as of August 1, 2011 the City will no longer be providing trash service and that the property owners need to arrange for disposal of their trash.

Trash Committee Meetings and Recommendations

On September 21, 2010, City Council convened a Trash Subcommittee and appointed Mayor Eric Busch, City Council Member Carl Jacobson and the five members of the Environmental Committee to evaluate and make recommendations to the City Council on future residential trash collection options and contracting. The Subcommittee met on three occasions over the past four months. At these meetings, the subcommittee reviewed, considered and assessed the following:

\(^1\) Consolidated’s original 1993 contract states that 3393 residential service addresses shall receive residential trash collection, but for more than a decade, staff reports have referenced 4475 service addresses as the actual number being served. However, there are only 4163 “service addresses” associated with 1-4 unit properties. Consolidated’s contract calls for an annual audit to confirm the number of addresses actually being served and a price adjustment if warranted., although no audit has been conducted since 1995 to confirm the actual number of service addresses receiving trash collection.
• The services currently provided to El Segundo residents;
• What services might be desirable in the next cycle;
• The current waste hauler’s performance level and relative customer satisfaction;
• The duration of past and future waste hauling contracts; and
• The current bidding environment based on what surrounding cities have experienced over the past two years.

The majority of the Trash Subcommittee determined that although the types of collection services currently provided to residents are adequate, it was worth investigating what other services could be provided that might improve service levels, the relative cost of those new services and whether the current bidding environment would yield a better price. After vetting these issues, the Trash Subcommittee concluded that a multi-tiered approach to the City’s future waste hauling contract and services was most suitable.

The Subcommittee, voting 5 to 1,\(^2\) recommends to City Council the following:

1. That the next residential trash collection services contract be publicly bid rather than renegotiated with Consolidated in order to ensure the best possible services at the lowest possible price.
2. That a multi-tiered Request for Proposals (RFP) be developed and released that includes all four (4) options listed in the table below. Responsive waste haulers would be required to submit separated bids for each of the options in order to provide El Segundo an apples-to-apples comparison measure against the current contract price and services.

The Subcommittee recognized that residents and the City are pleased with Consolidated’s service level, but feels that going out to bid is the most prudent approach for several reasons, which include:

• The contract has not been publicly bid in 18 years and therefore the City can no longer be assured its pricing is the best the market will bear.
• The current economy and aggressive bidding results as experienced by surrounding cities over the past year has resulted in lower contract pricing than previous contracts, thus raising questions about whether the City might actually obtain better pricing.

Additionally, Consolidated’s offer to hold the current contract pricing flat is based on implementing “no changes” in service level. However, if City Council decides to discontinue providing residential trash collections service to multi-unit unit properties (an estimated 36% reduction), then that is a change in service level. Neither staff nor Consolidated have discussed the pricing impact of this potential change and it is unknown at this time whether the $10.44 per parcel rate would still apply if the estimated number of parcels served is reduced.

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\(^2\) Six members of the Trash Subcommittee were present and one was absent.
## Trash Collection Services Currently Provided by Consolidated

This list is not meant to be exhaustive, but rather captures the main components of the services currently provided to residents and the City.

### Residential Services:
- Unlimited, weekly, manual curbside collection of trash, recyclables, and bulky items
- Curbside and centralized Holiday Tree recycling
- Centralized green waste collection
- Centralized recycling collection
- Twice annually bulky item collection events.

### City Services:
- Street-side trash receptacle collection
- Green waste roll off services
- Abandoned item collection in the public right-of-way
- Temporary bin service
- Permanent bin service for waste generated from City operations (e.g., asphalt haul off)

<table>
<thead>
<tr>
<th>Option No.</th>
<th>Description &amp; Comments</th>
<th>Recommendations</th>
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</table>
| Option 1   | Release an RFP for a new 3-year contract term with no service level changes. RFP should identify the same services currently provided by Consolidated. | - Maintain manual collection service.  
- Provide free larger recycling bins to residents who request them.  
- Request cost comparison for eliminating twice-annually bulky item collection events given that unlimited, weekly, bulky item pick-up is already provided curbside.  
- Request cost comparison for limited vs. unlimited curbside bulky item collection. |
| Option 2   | Release an RFP for a new 7-year contract term with no service level changes. | Same as Option 1, but includes receiving bids for services for an additional four (4) years. The price for years 4-7 would be identified separately from years 1-3. |
| Option 3   | Release an RFP for a new 3-year contract term requesting bids for significant service level changes. All service level changes would be identified as line item alternates for cost comparison against existing services. | - Obtain cost comparison to convert to automated or semi automated residential service everywhere feasible.  
- Obtain bid for providing unlimited, curbside green waste collection.  
- Provide multiple container size options (i.e., 35-gallon, 64-gallon) for trash, recycling and green waste.  
- Provide all collection containers for free.  
- Request cost comparison for eliminating twice-annually bulky item collection events given that unlimited, weekly, bulky item pick-up is already provided curbside to residents.  
- Request cost comparison for limited vs. unlimited curbside bulky item collection.  
- Limit hours for centralized, green waste collection at City yard to working hours.  
- Add recycling containers to street-side receptacle collection. |
| Option 4   | Release an RFP for a new 7-year contract term requesting bids for significant service level changes. | Same as Option 3, but includes receiving bids for services for an additional four (4) years. The price for years 4-7 would be identified separately from years 1-3. |