96-15

RESOLUTION NO. 3209

A Resolution of the Hemet City Council of Hemet, California
Recognizing and Providing For The Vested Rights of Retired Employees
to Post-Retirement Continuation of Health Benefits

WHEREAS, on November 1, 1969, the City joined the Myers-Geddes State Employees Medical and Hospital Care Act. And whereas, the City's health care program continued uninterrupted from November 1, 1969, until August 1, 1982, when by means of Resolution No: 2084, the City withdrew from the Myers-Geddes plan and established the CITY OF HEMET EMPLOYEES BENEFIT PLAN MEDICAL PLAN (hereinafter referred to as the "Plan"). Resolution 2084 provides in part:

> "The self-funded medical plan will continue to provide medical coverage for employees who have retired from the City of Hemet at the full-time regular employee rate."

A copy of Resolution No. 2084 is attached hereto as Exhibit "A".

WHEREAS, the Plan states in part the following:

> "THE CITY OF HEMET EMPLOYEE BENEFIT PLAN assures the Employees during the continuance of this Plan that all benefits hereinafter described shall be paid to them in the event that they and/or their eligible Dependent(s) incur medical expenses. The Plan is subject to all the terms, provisions and conditions recited on the following pages. (Emphasis added.)
>
> THE CITY OF HEMET EMPLOYEE BENEFIT PLAN has caused this Plan Document to take effect as of 12:01 A.M. Standard Time on August 1, 1982, at Hemet, California.
>
> This Plan Document and the benefits described herein supersede any and all previous Plan Documents and/or Amendments thereto. The benefits described will be effective for all claims incurred on or after the above date."

A copy of the Plan is attached hereto as Exhibit "B".

WHEREAS, upon implementation of the Plan, retired employees were removed from the State medical plan and enrolled in self-funded Medical Plan.

WHEREAS, on October 28, 1982, effective August 1, 1982, the Plan was amended by Amendment Number 1, which provided coverage for voluntary sterilization limited to vasectomy and tubal ligation. A copy of Amendment Number 1 is attached hereto as Exhibit "C".

WHEREAS, on October 15, 1986, effective August 1, 1986, the Plan was amended by Amendment Number 2, providing continuation of coverage for specified qualified beneficiaries. A copy of Amendment Number 2 is attached hereto as Exhibit "D".

WHEREAS, on December 17, 1986, effective August 1, 1986, the Plan was amended by Amendment Number 3, which amended the definition of 'waiting period.' A copy of Amendment Number 3 is attached hereto as Exhibit "E".

WHEREAS, on March 10, 1987, effective January 1, 1987, the Plan was amended by Amendment Number 4, which provided for vision and dental care. A copy of Amendment Number 4 is attached hereto as Exhibit "F".

WHEREAS, on December 11, 1987, effective January 1, 1987, the Plan was amended by Amendment Number 5, which provided clarification regarding coverage for vision and dental care for retired employees. A copy of Amendment Number 5 is attached hereto as Exhibit "G".

WHEREAS, on August 30, 1988, effective August 1, 1988, the Plan was amended by Amendment Number 6, which required pre-approval for hospital admissions. A copy of Amendment Number 6 is attached hereto as Exhibit "H".

WHEREAS, on December 23, 1988, effective January 1, 1989, the Plan was amended by Amendment Number 7, which deleted Amendment Number 6. A copy of Amendment Number 7 is attached hereto as Exhibit "I".

WHEREAS, on January 29, 1990, effective January 1, 1990, the Plan was amended by Amendment Number 8, which reduced the deductible to Twenty Dollars ($20). A copy of Amendment Number 8 is attached hereto as Exhibit "J".

WHEREAS, on January 21, 1990, effective January 1,1990, the Plan was amended by Amendment Number 9, which amended Amendment Number 4 increasing vision care to Three Hundred ($300) per calendar year per family. A copy of Amendment Number 9 is attached hereto as Exhibit "K".

WHEREAS, effective August 1, 1989, the Plan was amended by Amendment Number 10, by adding a prescription card service (PCS) to the prescription drug plan. A copy of Amendment Number 10 is attached hereto as Exhibit "L".

WHEREAS, effective August 11, 1992, the Plan was amended by Amendment Number 11, converting to a Preferred Provider Organization (PPO physicians). A copy of Amendment Number 11 is attached hereto as Exhibit "M".

WHEREAS, on July 24, 1990, effective June 27, 1990, the City Council approved Policies and Procedures for Retired Employees, a copy of which is attached hereto as Exhibit "N".

WHEREAS, on or about September 1, 1994, the City commenced the process of terminating the Plan replacing it with various market health plans.

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WHEREAS, the purchased health plans may have reduced the level of coverage of the Plan.

WHEREAS, the termination of the Plan may have resulted in medical coverage disadvantages to retired employees.

WHEREAS, all of the foregoing amendments and policies were unilaterally implemented.

WHEREAS, the City has had the issue of its potential liability reviewed by the firm of Richards, Watson and Gershon, and their opinion relating to the City's liability is attached hereto as Exhibit "O".

WHEREAS, on February 28, 1995 the Council adopted Resolution No. 3140, which, among other things, recognized the Retired Employees Association for the purpose of communicating with retired employees, and the Council's ad hoc committee has met with that group.

NOW THEREFORE BE IT RESOLVED:

1. The City Council finds that its termination of the Plan (City of Hemet Employee Benefit Plan) on or about September 1, 1994 and its substitution of the various market health plans resulted, in some cases, in a loss of health benefits for retired employees, which may have adversely affected their vested contractual rights to such health care benefits.

2. The City Manager is directed to cause the establishment of a schedule of benefits which identifies and specifies the vested contracted health benefits of retired employees and report back to the Council within 60 days.

3. The City Manager is further directed to include in his report a plan for restoring the loss of any vested contractual medical benefits to retired employees and a proposed written handbook describing retiree benefits.

4. The City Manager is further directed to include the Retired Employee Benefit Committee in the process of complying with the aforementioned schedule and report.

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5. The City Manager or his/her designee is hereby appointed as the liaison between the City and retired employees for the purpose of resolving future questions and disputes relating to retired employee rights and benefits.

ADOPTED by the Hemet City Council this 13th day of March, 1996 by the following vote:

AYES: Council Members Lowe, Tandy, Venable and VanArsdale
NOES: None
ABSTAIN: None
ABSENT: Council Member Schroeder

Lori VanArsdale
Mayor

ATTEST:

Brenda L. Weckerle
City Clerk

Robert T. Henderson
City Attorney

reso/hlthben.ret

RESOLUTION NO. 2084

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF HEMET, CALIFORNIA, ESTABLISHING POLICY FOR THE IMPLEMENTATION OF A SELF-FUNDED MEDICAL PROGRAM FOR THE CITY OF HEMET.

WHEREAS, the City Council of the City of Hemet wishes to withdraw from the State PERS medical program in order to self fund existing medical benefits.

NOW, THEREFORE BE IT RESOLVED AS FOLLOWS:

SECTION 1: Effective August 1, 1982 the City of Hemet will begin to self-fund the Blue Cross/Blue Shield medical benefits program.

SECTION 2: The self-funded medical plan will continue to provide paid medical coverage for employees who have retired from the City of Hemet at the full time regular employee rate.

SECTION 3: It is the intent of the City Council to contract with a Plan Administrator for the payment of all claims. The Mayor is hereby authorized to execute the contract agreement with the Plan Administrator.

SECTION 4: Dental coverage benefits with a $1000 maximum per year will be added to the Blue Cross/Blue Shield schedule of benefits. Combined together, these two schedules will make up the City's self-funded program.

SECTION 5: A self-insurance medical fund is hereby established. The fund balance of the medical fund will be restricted to fund medical and dental costs only.

MOVED, PASSED and ADOPTED at a regular meeting of the City Council of the City of Hemet, California, duly held on the 9th day of March, 1982 by the following vote:

AYES: Councilmembers Baskett, Herron, Morgan, Ward, Young.

NOES: None.

ABSENT: None.

ABSTAIN: None.

Attest:

Mayor, City of Hemet

City Clerk, City of Hemet

EXHIBIT "A"

CITY OF HEMET

EMPLOYEE BENEFIT PLAN

MEDICAL PLAN DOCUMENT

RESOLUTION NO. 3209

EXHIBIT B

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PLAN DOCUMENT

The CITY OF HEMET EMPLOYEE BENEFIT PLAN assures the Employees during the continuance of this Plan that all benefits hereinafter described shall be paid to them in the event that they and/or their eligible Dependent(s) incur medical expenses. The Plan is subject to all the terms, provisions and conditions recited on the following pages.

The City of Hemet EMPLOYEE BENEFIT PLAN has caused this Plan Document to take effect as of 12:01 A.M. Standard Time on August 1, 1982, at Hemet, California.

This Plan Document and the benefits described herein supersede any and all previous Plan Documents and/or Amendments thereto. The benefits described will be effective for all claims incurred on or after the above date.

DEFINITIONS

As Used Herein:

THE PLAN

The name of the Plan is City of Hemet Employee Benefit Plan of Hemet, California.

PLAN

The benefit and provisions for payment as described herein.

WAITING PERIOD

Eligible Employees are eligible for benefits as of the first day of work.

DEPENDENTS

a) Shall be spouse of the Covered Person and children between the ages of birth and 23 years, provided such children are unmarried, and dependent upon the Covered Person for support and maintenance. The term "children" shall include natural children, adopted children, foster children and step-children.

b) Shall include children provided they are unmarried and dependent upon the Covered Person for full support and maintenance.

c) Shall be a dependent child after his 23rd birthday provided the child is both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) chiefly dependent upon the Covered Person for support and maintenance, and was covered under this Plan before his 19th birthday. Proof of such incapacity and dependency must be

DEFINITIONS (Continued)

furnished the Plan by the Covered Person within thirty-one (31) days of the child's birthday. The Administrator may require, at reasonable intervals during the two (2) years following the Dependent's 23rd birthday, subsequent proof of the child's disability and dependency. After such two (2) year period, the Plan may require subsequent proof not more than once each year. The Plan reserves the right to have such Dependents examined by a doctor of the Plan's choice to determine the existence of such incapacity.

Excluded as Dependents under a, b, and c are:

1) Spouse legally divorced from the Employee; and

2) Any person while on active duty in any military of any country; and

3) Any person who is eligible for coverage under this Plan as an individual; and

d) No person may be covered as a Dependent of more than one (1) Employee of the City.

HOSPITAL

An institution for care of the sick or injured which is properly licensed or permitted legally to operate as such, and which has a licensed graduate Registered Nurse on duty twenty-four (24) hours a day, a Physician on call at all times, facilities for diagnosis of illness and for major surgery. The definition of Hospital shall be expanded to include any facility operating legally as a psychiatric hospital and licensed as such by the state in which the facility operates.

SEMI-PRIVATE CHARGE

The charge made by a Hospital for a room containing two (2) or more beds but does not include the charge made by the Hospital for Intensive Care.

OUT-PATIENT

A Covered Person shall be considered to be an Out-Patient if treated at a Hospital on a basis other than as a registered bed patient.

TOTAL DISABILITY

Total Disability shall mean that the Covered Person, if an Employee, is prevented, solely because of a non-occupational injury or non-occupational disease from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, or if a Dependent, is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in all of the normal activities of a person of like age and sex in good health. Certification of Total Disability must be made by a Physician.

CALENDAR YEAR

Means a period of one (1) year beginning with January 1.

MEDICARE

Means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

ADMINISTRATOR

City of Hemet
450 E. Latham
Hemet, California 92343
(714) 658-9411

DEFINITIONS

CONTRACT ADMINISTRATOR

Galbraith & Green, Inc.
275 Centennial Way
Tustin, California 92680
(800) 432-7005
(714) 838-6690

CONVALESCENT NURSING HOME
EXTENDED CARE FACILITY - SKILLED NURSING FACILITY

Means only an institution other than a Hospital, which meets all of the following requirements:

a) Maintains permanent and full-time facilities for bed care of ten (1) or more resident patients; and

b) Has available at all times the services of a Physician; and

c) Has a Registered Nurse (R.N.) or Physician on full-time duty in charge of patient care, and one (1) or more Registered Nurses (R.N.) or Licensed Vocational Nurses (L.V.N.) on duty at all times; and

d) Maintains a daily medical record for each patient; and

e) Is primarily engaged in prcare for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for custodial care or for the aged; and

f) Is operating lawfully as a Nursing Home or Extended Care Facility in the jurisdiction where it is located.

PHYSICIAN

Shall mean a person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Psychologist (Ph.D), Doctor of Chiropractic (D.C.), Clinical Social Worker, or Audiologist.

USUAL, REASONABLE AND CUSTOMARY CHARGES (URC)

Shall mean the normal and necessary charges made for similar services by 95% of the providers of medical service with like experience, education and training in the same geographical (Zip Code) area. Determination of whether a charge is URC shall be made by the Contract Administrator based on nationally obtained and recognized survey data.

HE, HIM, HIS

Wherever the masculine pronoun is used in this document it shall include the feminine gender unless the context clearly indicates otherwise.

INDIVIDUAL EFFECTIVE DATES

a) All eligible Employees and those covered Dependents, upon initiation of this Plan will be covered on the date of inception of the Plan provided they were covered under any prior plan and are actively at work on that date or available for work if it is not a scheduled work day; otherwise, they will be covered on the first day they are actively at work thereafter.

b) New Employees shall be covered as explained under Waiting Period in the Definitions section.

c) Dependents shall be covered on the same date as the new Employee providing application is made for coverage for them as Dependents and any required contributions for coverage are made to the City, providing they are not disabled on such Effective Date; otherwise, the Effective Date of coverage shall be delayed until the Dependent is released by his Physician as being able to resume his normal activities. Newborn children are covered from date of birth, provided enrollment is requested within sixty (60) days following birth, but shall only apply to:

   1) An illness contracted or an accident sustained after birth; or

   2) An abnormal congenital condition in the child; or

   3) A premature birth.

d) When a person enrolls later than sixty (60) days after his Eligibility Date, he shall submit a properly completed application on the Contract Administrator's form and shall furnish at his own expense evidence of good health satisfactory to the Contract Administrator. Upon approval by the Contract Administrator of such application and evidence of good health, the coverage shall then become effective on the date requested by the Administrator. An Evidence of Good Health Statement shall be waived during the Open Enrollment period.

e) If application for coverage or for reinstatement is made by a person who is in an eligible status but whose coverage had never become effective or had terminated because of failure to make the required contributions for coverage, the coverage for such person shall take effect only in accordance with the conditions set forth in part (d).

INDIVIDUAL EFFECTIVE DATES (Continued)

f) If additional Dependents are acquired while the individual is covered for Dependent coverage, the coverage for each such Dependent shall become effective on the date the Dependent qualifies in accordance with the definition of Dependent provision.

g) If no contributions are required from the individual for Dependent coverage, he will be deemed to have enrolled his Dependents on the date he becomes eligible for such coverage.

PRE-EXISTING CONDITIONS

Covered Persons will not be entitled to Covered Medical Expenses that are incurred as the result of an injury or sickness or a related injury or sickness for which any medical care or services has been received within a ninety (90) day period immediately prior to the Effective Date of coverage until the earliest of:

a) The expiration of three (3) consecutive months while coverage has been in effect, during which period no medical care or treatment for such injury or illness has been received; or

b) For an Employee, after six (6) consecutive months that coverage has been in effect, during which the Employee has been continuously at work and an Employee under the Plan; or

c) After the individual's coverage has been in effect for a period of twelve (12) consecutive months.

Pre-existing conditions are waived for those covered on the Effective Date of the Plan.

INDIVIDUAL TERMINATION OF COVERAGE

Coverage under the Plan shall terminate on the earliest of the following dates:

a) The date of termination of the Plan; or

b) The last day of the month that membership ceases in an eligible class; or

c) The date all coverage or certain benefits are terminated on the Covered Person's particular class by modification of the Plan; or

d) The date the Covered Person becomes a full-time member of the Armed Forces of any country; or

e) The last day of the month for which premiums are paid.

EXTENDED BENEFITS

If a Covered Person is totally disabled on the date his coverage terminates, the Major Medical Expense Benefit will be extended during the continuance of the disability with respect to the injury or sickness causing the disability if such person is not or does not become covered under any other plan which entitles such person to any benefits for sickness or injury. The benefits will be extended for the period equal to the time the Covered Person was enrolled under the Plan or a period of twelve (12) months from the date of termination, whichever is less.

SCHEDULE OF MEDICAL BENEFITS

BASIC BENEFITS

Hospital Room & Board, Miscellaneous	100% up to 365 days
Hospital Room and Board Maximum	Semi-Private
Skilled Nursing Facility	100% Semi-Private room rate*
Surgeon/Assistant Surgeon	100% of usual, reasonable and customary charges (URC)
Anesthesia	100% of usual, reasonable and customary charges
Physician In-Hospital Visits	100% of usual, reasonable and customary charges
Physician Home & Office Visits	100% for injury**
Out-patient Laboratory & X-ray	100% of usual, reasonable and customary charges up to $250 per calendar year
In-Patient Mental/Nervous Care	100% of usual, reasonable and customary charges up to 30 day maximum, and $50,000 maximum per disability
Ambulance	$50 per trip
Home Health Care	100% of usual, reasonable and customary charges, up to a maximum of 90 visits per calendar year

* Up to number of unused hospital days - maximum 365 days combined. A new 365 days of care will renew 30 days after discharge.

** After $50 deductible, 100% for illness.

SCHEDULE OF BENEFITS (Continued)

MAJOR MEDICAL

Maximum Benefit per Disability	$300,000
Individual Deductible	$100 per calendar year
Family Deductible	$200 per calendar year
Co-Payment	80% of the first $15,000 of eligible charges paid by the Plan and 100% of eligible charges thereafter during the same calendar year for that individual***

*** Psychiatric charges for out-patient services will remain 50% of a $40 maximum charge to a yearly maximum of $750.

BASIC MEDICAL BENEFITS

HOSPITAL

If a Covered Person incurs necessary expenses which are recommended and approved by a Physician, for Hospital care for diagnosis or treatment of an illness or injury, the Plan will pay Hospital charges not exceeding the maximum amount specified in the Schedule of Medical Benefits for such charges.

ROOM & BOARD/GENERAL NURSING CARE

The Plan will pay the amount charged by the Hospital for a Covered Person who is confined as a registered bed patient for Room, Board and General Nursing Care, not to exceed the amount of Hospital Room and Board Daily Benefit in the Schedule of Medical Benefits for any one (1) continuous confinement.

HOSPITAL MISCELLANEOUS EXPENSE

The Plan will pay the reasonable and customary amounts charged by the Hospital for necessary services, medicines, blood plasma not replaced, and supplies for diagnosis or treatment of the illness or injury, for which the Covered Person is confined (except services of a Physician, Dentist, special nursing in any form, drugs or supplies not consumed or used in the Hospital) and not exceeding the Hospital Miscellaneous Expense Maximum Benefit provided in the Schedule of Medical Benefits during any one (1) period of confinement provided the Covered Person is Hospital confined as a registered bed patient, or the Covered Person has surgery performed in the Hospital or, the Covered Person receives necessary emergency treatment as a result of and within twenty-four (24) hours of time of an accident.

RELATED HOSPITAL CONFINEMENT

Separate confinement of a Covered Person will be considered related unless:

a) The later confinement commences after complete recovery from the sickness or injury causing an earlier confinement; or

b) The later confinement results from causes entirely unrelated to the causes of an earlier confinement; or

c) In the case of an Employee, the confinements are separated by a return to active employment.

BASIC MEDICAL BENEFITS (Continued)

HOSPITAL EXTENDED BENEFIT

If confined in an accredited Hospital at time of termination of coverage, Hospital benefits will continue until discharged.

SKILLED NURSING FACILITY

The Plan will pay up to the amount indicated in the Schedule of Medical Benefits for services and supplies related to confinement in an Extended Care Facility or skilled nursing facility.

SURGEON

The Plan will pay the Usual, Reasonable and Customary charge for necessary charges for a surgeon for surgical expenses incurred as recommended and approved by a Physician, not to exceed the Surgical Benefit as provided in the Schedule of Medical Benefits.

ASSISTANT SURGEON

The Plan will pay the Usual, Reasonable and Customary charge for necessary charges for an Assistant Surgeon, not employed by the Hospital, not to exceed the Assistant Surgeon Benefit, as specified in the Schedule of Medical Benefits.

AMBULANCE

The Plan will pay up to the amount indicated in the Schedule of Medical Benefits for Ambulance charges per disability for a trip to or from the Hospital or Extended Care Facility. Ambulance benefits are payable only for services rendered by a professional ambulance company whose primary business is the transportation of sick or injured and then only payable if the condition being treated is a covered expense.

ANESTHESIA

The Plan will pay the Usual, Reasonable and Customary expense incurred for the administration of anesthetics while the Covered Person is entitled to regular Hospital and Surgical Benefits not to exceed the Anesthesia Benefit provided in the Schedule of Medical Benefits.

PHYSICIAN IN-HOSPITAL VISITS

The Plan will pay for Physician's Hospital Visits, up to the amount specified in the Schedule of Medical Benefits, provided the Covered Person is Hospital confined. Hospital visits by a Physician shall mean professional calls rendered in person.

OUT-PATIENT X-RAY AND LABORATORY

The Plan will pay up to the amount specified in the Schedule of Medical Benefits for services made by the Out-Patient Department of a Hospital, doctor's office or other facilities for x-rays, laboratory tests when prescribed by a Physician and necessary for the treatment of an active illness or injury. "Pap" smears are a covered benefit.

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HOME HEALTH CARE

The Plan will pay participating providers for any of the following up to a combined total of ninety (90) visits each calendar year: licensed nurse, occupational, speech and physical therapists; medical social workers and health aides. The Plan does not provide for housekeeping services, hemodialysis or maintenance therapy.

BASIC MEDICAL BENEFITS (Continued)

PREGNANCY BENEFITS

The Plan will provide coverage for pregnancy, including prenatal, obstetrical, and post-partum care, and any complications.

ALCOHOLISM AND DRUG ADDICTION BENEFITS

In-Hospital

When a Covered Person requires in-patient services for treatment of alcoholism or drug addiction during a hospitalization for which Hospital Benefits are payable, the Plan will pay the Usual, Reasonable and Customary (URC) charges for services of a Physician for a period not exceeding thirty (30) days during a calendar year.

Out-of-Hospital

After the $50 deductible is met under the Home and Office benefit, the Plan will pay the Usual, Reasonable & Customary (URC) charges of a Physician for treatment provided on an out-patient basis for alcoholism or drug addiction. This benefit is limited to thirty (30) visits during a calendar year.

CHEMOTHERAPY

Chemotherapy benefits are provided on an episodic basis for chemotherapy provided by a Physician in the Out-Patient Department of a Hospital, the Physician's office or the patient's home. Coverage is provided for the following categories of therapy:

a) Parenteral (excluding subcutaneous or intramuscular)

b) Infusion (continuous or intermittent)

c) Perfusion

d) Intracavitary

Payment by the Plan is based on the Usual, Reasonable and Customary (URC) charges. Included in this payment are all costs related to the following services: catheterization, Physician visits, costs of drugs and solutions, pump regulations and servicing.

Benefits are not provided for oral chemotherapy, subcutaneous or intramuscular injections of drugs or experimental or research chemotherapy drugs (antineoplastic agents). This benefit is not subject to the deductible amount of $50 under the Home and Office benefit.

MAJOR MEDICAL EXPENSE BENEFIT

If a Covered Person has incurred Covered Medical Expenses, the Plan will pay the percentage indicated in the Schedule of Medical Benefits section of the Usual, Reasonable, and Customary charges for such Covered Medical Expenses.

The benefits payable shall not exceed the Maximum Amount and are subject to the Deductible Amount specified herein and are subject to all limitations and conditions of the Plan.

MAXIMUM AMOUNT

The Maximum Lifetime Amount payable hereunder shall be the amount indicated in the Schedule of Medical Benefits section for all disabilities.

REINSTATEMENT

At the beginning of each Calendar Year, any previously used portion of a Covered Person's full Maximum Amount per disability, will automatically be reinstated, subject to the following:

Reinstatement of Maximum with Evidence of Good Health

If a Covered Person with respect to whom benefits of at least $2,000 have been paid for a disability submits at his own expense evidence of good health satisfactory to the Administrator, the Administrator will give its written consent to the reinstatement of the Maximum Benefit for that disability. Reinstatement shall be effective for Covered Medical Expenses and supplies incurred on or after the date of such written notice of reinstatement.

Reinstatement without Evidence of Good Health

On January 1 of each year the $300,000 Maximum Benefit will be automatically reinstated, subject to the following:

This reinstatement will apply separately to each Covered Person, but not more than $1,000 shall be reinstated in any one year. Reinstatement will operate as follows:

In the event that benefits have been paid or accrued for more than one disability, benefits will first be reinstated for that disability for which the greatest amount of benefits have been accumulated. If less than $1,000 is required to reinstate the $300,000 Maximum, the balance will be applied to the disability for which the next highest amount of benefits has been accumulated.

MAJOR MEDICAL EXPENSE BENEFITS (Continued)

DEDUCTIBLE AMOUNT

The term Calendar Year Deductible means the amount, as stated in the Schedule of Medical Benefits, of Covered Medical Expenses which must be incurred by a Covered Person before Major Medical Benefits become payable.

If, during a Calendar Year, cash deductibles have been satisfied, as provided in the preceding paragraph, by persons who are members of the same family, and if the sum of such cash deductibles is equal to the Maximum Deductibles per family shown in the Schedule of Medical Benefits, the cash deductible requirement is waived from that point in time with respect to any remaining members of that family, for the remainder of such Calendar Year. For the purposes of this provision, a family means an Individual and his Dependents.

If two (2) or more Covered Persons in the same family are injured in a common accident, the cash deductible applicable for that common accident shall be limited to a single cash deductible amount for that Calendar Year.

If during the last three (3) months of a Calendar Year, a Covered Person incurs Covered Major Medical Expenses applicable to the cash deductible, such expenses shall also be applicable to the cash deductible, for the next succeeding calendar year.

Accumulated deductibles which were satisfied by persons under the prior Plan from January 1 of the year this Plan became effective to the Effective Date of this Plan, will be honored provided the persons are covered on the Effective Date of this Plan and provided the Administrator makes known to the Contract Administrator the amounts of such previously accumulated deductibles.

COVERED MAJOR MEDICAL EXPENSES

All Covered Major Medical Expenses are subject to the applicable deductibles and co-payments listed in the Schedule of Medical Benefits and shall include only Usual, Reasonable and Customary charges for the services and supplies described below which are incurred by a Covered Person and not reimbursed under the Basic Medical Benefits (if any):

a) Hospital care for Room, Board and other Hospital services required for purposes of treatment, but not to exceed for Hospital Room and Board the cost of a Semi-Private room or other accommodations deemed medically necessary by the Attending Physician; and

b) Medical or surgical services by a Physician; and

c) Treatment for mental or nervous conditions by a Physician, Psychiatrist or Psychologist (Ph.D.); and

d) Professional services, recommended by a Physician, from a graduate Registered Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), or a Registered Physical Therapist (R.P.T.), such services shall not include a California Registered Nurse Midwife acting within the scope of his license; and

e) The following medical services or supplies that are recommended by a Physician:

   1) Drugs and medicines requiring a Physician's prescription;

   2) Anesthesia, including the charge for administration;

   3) Diagnostic laboratory and x-ray services;

   4) Oxygen and/or rental of equipment required for its administration;

   5) X-ray, radium and radioactive isotope therapy;

   6) Braces, crutches, casts, splints, blood (if not replaced), or other fluids actually injected into the circulatory system;

   7) Initial artificial limb or eyes or other prosthetic appliances;

COVERED MAJOR MEDICAL EXPENSES (Continued)

8) Rental or purchase of durable medical equipment prescribed by a Physician and required for temporary therapeutic use in the treatment of an active illness or injury;

9) Necessary emergency transportation of the Covered Person by a professional ambulance, to or returning from a Hospital or other medical institution for covered medical treatment considered a medical necessity by a licensed Physician;

f) Maternity expenses for Employees and Spouses. Abortions are not covered except when the life of the Covered Person is in danger; and

g) Speech Therapy: This benefit pays the percentage payable for the services of a qualified speech therapist (one who holds a certificate of competence in clinical speech pathology from the American Speech and Hearing Association) for correction of a speech impediment incurred while covered under this Plan if caused by illness or injury or due to surgery on account of illness. Speech impediments due to congenital anomalies are included only after corrective surgery. Speech impediments due to cerebral palsy, considered a congenital condition, will also be covered without corrective surgery. Charges for speech therapy due to functional nervous disorders are excluded. The maximum lifetime benefit payable is $5,000.

Charges of all medical expenses shall be deemed incurred on the latest of the following:

a) The date a purchase is contracted; or

b) The date delivery is made; or

c) The actual date a service is rendered.

MEDICAL LIMITATIONS

No benefits shall be payable under the Basic or Major Medical sections listed above with respect to:

a) Any treatment or service not prescribed or recommended by a Physician as defined in the Definitions section; or

b) Any amount for a service, supply or treatment not recognized as generally accepted in medical practice as necessary for the diagnosis or treatment of an active illness or injury; or

c) Any charges for hearing examinations, hearing aids, eye examinations, glasses or correction of vision or fitting of glasses; or

d) Any charges for dental services or treatment except dental treatment for the repair or alleviation of bodily injury sustained while insured under this benefit; or

e) Any condition, disability or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act, participation in civil insurrection or a riot, duty as a member of the Armed Forces of any state or country, war or act of war declared or undeclared; or

f) Any services for care or treatment provided or furnished by the United States Government or the government of any country, by the Veterans Administration, federal, state or county government, or by any government unit unless the Covered Person is legally required to pay without regard to the existence of coverage; or

g) Any services for which a charge would not have been made in the absence of coverage; or

h) Any amount for a service rendered by a person related to the Covered Person by blood or marriage; or

i) Any benefit under the Worker's Compensation Act or similar legislation, or which is due to injury arising out of or in the course ofany occupation or employment for wage or profit, except as specifically provided in the Plan; or

MEDICAL LIMITATIONS (Continued)

j) Vaccinations, inoculations, preventive shots and routine physical examinations; or

k) Expenses incurred for routine care furnished to a newborn child; or

l) Expenses incurred for the treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease; or

m) Any charges for cosmetic surgery except as the charges relate to such surgery to correct a congenital defect in a covered newborn or to repair the effects of an accident which occurred while the individual is covered under this Plan; or

n) Any charges related to services for voluntary sterilization; or

o) Any charges related to the treatment of self-inflicted injuries, illegal drug use or drug overdoses; or

p) Any charges made in connection with an organ transplant, except that this exclusion shall not apply when:

1. The transplant is of a cornea, kidney or bone marrow, and

2. The recipient of such transplant is a covered person; or

q) Charges for acupuncture; or

r) Intersex surgery (trans-sexual operation or complications arising therefrom); or

s) Occupational, vocational, educational, recreational, art, dance or music therapy; or

t) Weight control programs or exercise programs; or

u) Hospitalization primarily for x-ray, laboratory or any other diagnostic studies or medical observation; or

v) Hyperkinetic syndromes, learning disabilities, behavorial problems, mental retardation or autistic disease of childhood.

COORDINANION OF BENEFITS

This provision shall apply to all sections of the Plan providing reimbursement for medical care expenses including coverage for those individuals covered under Medicare, except Effect on Benefits section, sub-paragraphs (c) and (d) does not apply to Medicare. This Plan will always pay benefits secondary to Medicare. If a Covered Person is eligible to enroll for Medicare, but fails to do so, this Plan will coordinate with the benefits that would have been paid by Medicare if enrolled.

Definitions Applicable to This Provision

The term Plan as used in this provision means any plan providing benefits or services for medical or dental care or treatment, which benefits or services are provided by (a) group, blanket or franchise insurance coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan, including any federal or state or other governmental plan or law, or (b) coverage under any plan solely or largely tax-supported or otherwise provided for by or through action of any government.

The term Plan shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services separately with respect to that portion of any such policy, contract, or other arrangement, which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"This Plan" as used in this provision means that portion of the contract by name referred to in this document which provides the benefits that are subject to this provision.

Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one (1) of the Plans covering the person for whom claim is made.

When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period means Calendar Year.

COORDINATION OF BENEFITS (Continued)

Effect on Benefits

a) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period, if for the Allowable Expenses incurred, the sum of the following would exceed such Allowable Expenses:

1) The benefits that would be payable under this Plan in the absence of this provision, and

2) The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision.

b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

c) If another plan involved in item (b) contains a provision coordinating its benefits with those of this Plan and would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and the rules set forth in item (d) would require this Plan to determine its benefits after such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under this Plan.

d) For the purposes of item (c), the rules establishing the order of benefit determination are:

1) The benefits of a plan which does not contain a provision for coordinating its benefits with those of this Plan shall be determined first.

2) The benefits of a plan which covers the person on whose expenses the claim is based other than as a Dependent shall be determined before the benefits of a plan which covers such person as a Dependent.

COORDINATION OF BENEFITS (Continued)

3) The benefits of a plan which covers the person on whose expenses the claim is based as a Dependent child of a male person shall be determined before the benefits of a plan which covers such person as a Dependent child of a female person.

a) When a father and mother are legally separated or divorced, the benefits of a plan which covers the person on whose expenses the claim is based as a Dependent child of the biological parent having legal custody shall be determined before the benefits of plan which covers such person as a Dependent of the biological parent not having legal custody.

b) When a father and mother are divorced and the spouse granted legal custody has remarried, the benefits of a plan which covers the person on whose expenses the claim is based as a Dependent of the step-parent shall be determined before the benefits of a plan which covers such a person as a Dependent of the biological parent not having legal custody.

4) When rules (1), (2), and (3) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

COORDINATION OF BENEFITS (Continued)

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan(s), the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the City or shall be fully discharged from liability under this Plan.

Recovery of Excess Payments

Whenever payments have been made by the Plan with respect to Allowable Expense in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

FACILITY OF PAYMENT

If, in the opinion of the Contract Administrator, a valid release cannot be rendered for the payment of any benefit payable, under this Plan, the Contract Administrator may, at its option, make such payment to the individual or individuals as have, in the Contract Administrator's opinion, assumed the care and principal support of the Covered Person and are, therefore, equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him have been made, the Contract Administrator, may at its sole discretion and option, honor benefit assignments, if any, made prior to the death of such Covered Person.

Any payment made by the Contract Administrator in accordance with the above provisions shall fully discharge the Plan to the extent of such payments.

APPEAL PROCEDURES

Remedies Available Under the Plan for the Redress of Claims Which are Denied in whole or in Part, including Provisions Required by Section 503 or ERISA: This appeal provision will have to be determined by the Administrator of each respective plan and set forth herein with particularity. An example of such a procedure is as follows:

a) A review of the eligibility status for any claim denied in whole may be submitted to the Administrator.

b) Any Claimant may request the provider of benefits for a review of any claim payments. Such requests must include the name of the Employee and the Social Security Number, the name of the patient and Group Identification Number, if any.

c) The Claimant must file his request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of his claim.

The request for review should be directed to the appropriate office within sixty (60) days after the claim payment date or the date of the notice of denial of benefit.

MISCELLANEOUS PROVISIONS

SUMMARY PLAN DESCRIPTION (BOOKLET)

The Plan will issue to each Employee covered under this Plan an individual booklet which shall summarize the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan principally affecting the Covered Person.

ASSIGNMENT

The Covered Person's benefits may not be assigned except by consent of the Plan.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan, which on its Effective Date, is in conflict with the statutes of the jurisdiction of California, which relates to Self-Funded plans is hereby amended to conform to the minimum requirements of such statutes.

NOTICE AND PROOF OF CLAIM

Written notice of claim hereunder must be given to the Plan at GALBRAITH & GREEN, INC., 275 Centennial Way, Tustin, California 92680, or to the Administrator of the Plan with particulars sufficient to identify the Covered Person, within 365 days of the date such claim was incurred.

The Plan or the Administrator upon receipt of notice required by the Plan will furnish to the Covered Person or to any other person notifying the Plan of claim such forms as are usually furnished by it for filing proof of loss.

If such forms are not furnished within fifteen (15) days after receipt of such notice, the Covered Person shall be deemed to have complied with the requirements of the Plan, as to proof of loss, upon submitting written proof fully describing the occurrence for which claim is made.

Failure to furnish notice or proof of claim within the time provided in the Plan shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.

SIGNATURE PAGE

The Effective Date of this Plan Document is August 1, 1982.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT PLAN, that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of said Employer's Benefit Program described herein.

SIGNED AT Hemet this 1st

day of June, 19 85.

BY Patricia A. Lenn

TITLE Mayor

WITNESS:

RESOLUTION NO. 3209

EXHIBIT G

RESOLUTION NO. 3209

EXHIBIT C

AMENDMENT NUMBER 1

TO THE PLAN DOCUMENT OF THE

CITY OF HEMET EMPLOYEE BENEFIT PLAN

The Plan Document of the City of Hemet Employee Benefit Plan is hereby amended as follows:

> Item N under Medical Limitations, page 20 of the plan document is hereby deleting, thereby voluntary sterilization, to include and limited to vasectomy and tubal ligation shall become a covered expense under the Basic Benefit section payable at 100% of Usual, Reasonable and Customary (URC).

The effective date of this amendment is August 1, 1982.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT PLAN that the provisions contained in the Plan Document and Amendment Number 1 thereto are acceptable and will be the basis for the administration of said Employer's Benefit Program described herein.

SIGNED AT HEMET THIS 28 day of

OCTOBER, 19 82.

BY Steve Semple

TITLE: Director of Finance

WITNESS: Kathleen M. Franklin

EXHIBIT "C"

AMENDMENT NUMBER 2

To The Plan Document of

CITY OF HEMET EMPLOYEE BENEFIT PLAN

The Plan Document of the CITY OF HEMET EMPLOYEE BENEFIT PLAN is hereby amended as follows:

Coverage Continuation

Each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation of coverage under the plan.

A. Definitions

1. "Covered Employee" means an individual who is (or was) provided coverage under the group health plan by virtue of the individual's employment or previous employment with the employer.

2. "Qualified Beneficiary" means an employee participating in the group health plan, and any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan, as the employee, as the spouse of the employee, or as the dependent child of the employee.

3. "Qualifying Event" means any of the following events which would result in loss of coverage for a qualified beneficiary were it not for the coverage requirements of this section:

   (a) Death of covered employee;

   (b) Termination (other than by reason of such employee's gross misconduct) of the covered employee's employment;

   (c) The divorce or legal separation of the covered employee by the employee's spouse;

   (d) The covered employee becomes a Participant in benefits offered under Title XVIII of the Social Security Act (Medicare).

   (e) A dependent child becomes an ineligible dependent child under the former requirements of the plan;

   (f) Reduction of hours to fewer than the minimum required for participant in the Plan.

4. "Period of Coverage" means the period beginning on the date of the qualifying event and lasting until the earliest of the following:

   (a) 18 months after the date of the qualifying event if the qualifying event is termination or reduction of hours;

   (b) 36 months after the date of the qualifying event for all other qualifying events.

5. Notwithstanding any of the provisions of Paragraph 4(a) and 4(b), the period of coverage shall terminate upon the occurrence of any of the following events;

   (a) The date on which the employer ceases to provide any group health plan to any employee;

   (b) The date on which coverage ceases under the plan because payor fails to make timely payment of any premium required under the plan;

   (c) The date on which the qualified beneficiary first becomes a covered employee under any other group health plan or entitled to benefits under Title XVIII of the Social Security Act;

   (d) The date on which the beneficiary remarries and becomes covered under a group health plan in the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee.

6. "Election Period" means the period in which each qualified beneficiary must elect coverage continuation. The period commences the later of the qualifying event or the receipt of the notice specified in subparagraph B.3 and terminates 60 days after the receipt of the notice of rights under termination.

B. <u>Notice of Qualifying Events</u>

1. The employer must notify the plan administrator within thirty (30) days of the date of the qualifying event if the qualifying event is the death of the covered employee, termination (other than by reason of such employee's gross misconduct) or reduction of hours of the covered employee's employment, or the covered employee becomes entitled to benefits under Title XVIII of the Social Security Act.

2. Each covered employee or qualified beneficiary is responsible for notifying the plan administrator if the qualifying event is the divorce or legal separation of the covered employee by the employee's spouse or if a dependent child ceases to be a dependent child under the generally applicable requirements of the plan.

3. In the event of any of the qualifying events referred to in subparagraphs 8.1 or 8.2 above, the plan administrator shall notify any qualified beneficiary with respect to the qualifying event of such beneficiary's rights under Coverage Continuation within fourteen (14) days of the date on which the plan administrator learns about a qualifying event. Notification to the individual who is a qualified beneficiary, as the spouse of the covered employee shall be treated as notification to all other beneficiaries residing with the spouse at the time notification is made.

C. Premium for Self-Funded Plans

The qualifying beneficiary shall pay the premium for any period of continuation coverage. The premium shall be equal to the cost to the plan for similarly situated beneficiaries for the same period occurring during the coverage period. The premium shall be adjusted by the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12 month period ending on the last day of the sixth month of such preceding determination period.

Notwithstanding the preceding, if there is a significant adjustment, then the premium that the qualified beneficiary shall pay shall be equal to a reasonable estimate of the cost of providing coverage during the period for similarly situated beneficiaries.

D. Conversion Option

The qualifying beneficiary has 180 days, commencing on the expiration date of the continuation coverage period, to elect to enroll in any conversion health plan sponsored by the Employer if the qualified beneficiary's period of continuation coverage expires after 18 months.

E. Guaranteed Eligibility

Participation in continuation coverage by a qualified beneficiary is not conditioned upon evidence of insurability.

F. Notice of Continuation Coverage

The plan sponsor shall provide written notice of rights under these Continuation Coverage requirements to each covered employee and spouse of the employee at the time of commencement of coverage under the plan.

Page 1. Definitions: Addition

COVERED PERSON

A regular full-time permanent employee of the City of Hemet who works 40 hours per week, including fire suppression personnel who are considered regular full-time permanent employees regardless of schedule; or

Employees who have retired from service with the City of Hemet and qualify for coverage pursuant to the retired employee benefit policy.

Page 1. Definitions: Amend

WAITING PERIOD

Eligible employees are eligible for benefits as of the first day after 30 days of continuous employment.

Page 4. Contract Aministrator: Amend

The Contract Administrator is ALTA Administrators.

Page 9. Schedule of Medical Benefits: Amend

In-Patient Mental/Nervous Care (Hospital and Physician Charges)	100% of usual, reasonable and customary charges up to a 30 day maximum per occurrence, and $50,000 lifetime maximum per disability.

Page 21. Acts of Third Parties: Addition

ACTS OF THIRD PARTIES

If in the opinion of the Contract Administrator it appears a Covered Person may have been injured through the act or omission of another person, the Trust shall provide the benefits of this contract only on condition that the Employee shall agree in writing:

a) To reimburse the Trust to the extent of benefits provided, immediately upon collection of damages, whether by legal action, settlement or otherwise, and

b) To provide the Trust with a completed and signed Lien and Order Directing Reimbursement of Medical Payments, to the extent of benefits provided by the Trust.

In the event claimant fails to, or refuses to execute whatever assignment, form or document requested by the contract administrator of the plan, the plan shall and is hereby relived of any and all legal, financial, or contractual obligation contained in this the entire plan for any benefits or covered expenses incurred by claimant.

Page 24. Section 102(b) ERISA Requirements: Addition

1) The Name and Type of Administration of the Plan:

The City of Hemet Employee Benefit Plan to reimburse injury and illness claims.

2) Name and Address of the Person designated as Agent for the Service of Legal Process:

Edward J. Rodeghier, City Clerk
City of Hemet
450 E. Latham
Hemet, CA 92343

3) Name and Address of the Administrator:

City of Hemet
450 E. Latham
Hemet, CA 92343

4) Names, Titles and Addresses of any Trustee or Trustees:

City of Hemet
450 E. Latham
Hemet, CA 92343

5) Description of the Relevant Provisions of any applicable Collective Bargaining Agreement:

A) Memorandum of Understanding
Non-Safety Unit (General Employees) of Public Employees Association of Riverside County, Inc.

B) Memorandum of Understanding
Hemet Police Employees Association, Inc.

C) Memorandum of Understanding
Hemet City Firefighters Local #2342

6) Source of Financing of the Fund and Identity of any Organization through which benefits are provided:

The City of Hemet Employee Benefit Plan

7) Plan Year End:

July 31st

8) Internal Revenue Service Taxpayer Identification Number:

95-6000179

9) The Plan's Requirements Respecting Eligibility for Participation and Benefits:

See Individual Effective Dates.

10) Description of Circumstances which May Result in Disqualification, Ineligibility or Denial or Loss of Benefits:

See Individual Termination of Coverage and Coordination of Benefits.

11) Procedure to be Followed in Presenting Claims for Benefits Under the Plan:

See Notice and Proof of Claim.

12) Remedies Available Under the Plan for the Redress of Claims Which are Denied in Whole or in Part, including Provisions Required by Section 503 or ERISA: The review procedure is as follows:

a) A review of the eligibility status for any claim denied in whole may be submitted to the Administrator.

b) Any claimant may request the provider of benefits for a review of any claim payments. Such requests must include the name of the employee and the social security number, the name of the patient and group identification number, if any.

c) The claimant must file his request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of his claim.

The request for review should be directed to the appropriate office within sixty (60) days after the claim payment date or the date of the notice of denial of benefit.

The effective date of this amendment is August 1, 1986.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT PLAN that the provisions contained in the Plan Document and Amendment Number 2 thereto are acceptable and will be the basis for the administration of said Employer's Employee Benefit Program described therein.

SIGNED AT Hemet, California this 15th day of October, 1986.

BY _____
Lyle W. Alberg

TITLE City Manager

WITNESS:

_____

C:TU/HEMET-1/7

RESOLUTION NO. 3209

EXHIBIT E

AMENDMENT NUMBER 3

To The Plan Document of

CITY OF HEMET EMPLOYEE BENEFIT PLAN

The Plan Document of the City of Hemet Employee Benefit Plan is hereby amended as follows:

Page 1, Definitions

WAITING PERIOD

Eligible Employees are eligible for benefits the first of the month following date of hire, not to exceed 30 days.

The effective date of this Amendment is August 1, 1986.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT PLAN that the provisions contained in the Plan Document and Amendment Number 3 thereto are acceptable and will be the basis for the administration of said Employer's Employee Benefit Program described therein.

SIGNED AT HEMET this 17th day of December, 1986.

BY Steve Lengh

TITLE Director of Finance

WITNESS:

Lisa M Gonzalez-Castagna

EXHIBIT "E"

RESOLUTION NO. 3209

EXHIBIT F

AMENDMENT NUMBER 4

To The Plan Document of

CITY OF HEMET EMPLOYEE BENEFIT PLAN

The Plan Document of the City of Hemet Employee Benefit Plan is hereby amended as follows for the police employees:

CITY OF HEMET
VISION CARE PLAN

MAXIMUM BENEFIT PAYABLE

$150 per calendar year per family

$300 in first year of Plan*

Employees currently enrolled in the medical benefit program as of January 1, 1987, will have a Maximum Benefit Payable of $300 in the first year of the Plan. Thereafter, Maximum Benefit Payable will be $150 per calendar year per family.

DEDUCTIBLE

NONE

CARRYOVER UNUSED BENEFIT

Up to $150 of unused benefit may be carried over to the next year.

ELIGIBLE SERVICES

Lenses, frames, eye examinations, fittings of eyeglasses, and fittings of contact lenses.

LIMITATIONS-PAYMENT WILL NOT BE MADE FOR:

a. More than two complete visual analyses, including refraction in any twelve (12) month period.

b. Services covered under the medical portion of the Plan.

CITY OF HEMET
DENTAL CARE PLAN

MAXIMUM AMOUNT

Annual Maximum per Covered Person	$1,500
Orthodontic Lifetime Maximum per Covered Person	$2,000
Deductible Amount	$ 50

CO-PAYMENT

Class 1. Preventative and Diagnostic Services: 80%
Preventative and Diagnostic dental work is defined as full mouth and re-call X-rays, routine preventative dental examinations; flouride treatment and Prophylaxis. Prophylaxis is limited to once every six months.

Class 2. Major Services: 80%
Major Dental work is defined as restorative and pallative, as well as periodontics, endodontics, and oral surgery.

Class 3. Major Services: 50%
Major Dental work is defined as prosthodontics and restorative work requiring gold and any other crown or bridgework.

Class 4. Orthodontic Services: 50%

All covered Dental Expenses are subject to the applicable Maximum Amount(s), Deductible Amount and, Co-Payments listed in the Schedule of Dental Benefits and shall include only Usual, Resonable and Customary charges for services described below which are incurred by a Covered Person and performed by a legally qualified Dentist.

ORTHODONTIC BENEFIT

The Plan's payment shall be based on a lifetime maximum of $2,000 and will be pro-rated over the number of months to completion of the treatment. The payment shall be payable on such terms and conditions as are arranged between the Covered Person and the Professional Provider.

A. Plan benefits cover usual and customary orthodontic treatment.

B. The following benefits are not included as orthodontia:

1. Cephalometric X-rays
2. Tracings
3. Case studies
4. Lost or broken appliances
5. Re-treatment or orthodontic cases
6. Cases involving the following:

a. surgical orthodontics
b. myofunctional therapy
c. micrognathia
d. hormonal imbalances

C. Should a Member be terminated for whatever reason, and be receiving any orthodontic treatment at the time of termination, the Member and not the Plan will be responsible for payment of the balance due for treatment after the termination date.

D. Should this Agreement be terminated by either Party hereto due to breach or non-renewal at the end of any applicable term, the provisions of Section II E.1.d above shall apply with respect to a Member being treated for orthodontic work which is not completed at the date of termination.

E. Extractions for orthodontic purposes only are not a covered benefit.

F. Diagnostic work-up (consultation and diagnosis on cases where treatment is prescribed) is payable only if Member does not proceed with the prescribed treatment. $50.

PRINCIPAL LIMITATIONS

A. Worker's Compensation. Should any benefit or service rendered result from a Worker's Compensation Injury Claim, the Member shall assign his/her right to reimbursement from any other sources to the Plan or to the Professional Provider who rendered the service. It applies separately to the Member and each Dependent each Plan year, with one exception. If two or more Members of the same family are injured in the same accident, only one case deductable will be applied each Plan year against all of the covered charges incurred as a result of such accident.

B. Dentures. Full or partial replacements will be made only if existing dentures are unsatisfactory and cannot be made satisfactory, and then the following would apply:

1. Charges for full or partial dentures, fixed bridges or tooth additions to existing dentures, if required because of a loss of natural teeth, are paid by the Plan. Replacement of an existing prosthesis that is over five years old and cannot be made serviceable is also covered.

2. Charges for repairing and rebasing existing dentures which have not been replaced by a new denture are also paid by the Plan.

3. Covered charges for both a temporary and a permanent prosthesis will be limited to the charges for a permanent one only. Charges for specialized techniques involving precision attachments, personalization or characterization, and additional charges within six months or installation are not covered benefits.

C. Prophylaxis. These "teeth cleanings" are allowable only once every six months.

D. Relines. These are limited to only twice per year.

E. Full mouth X-rays. These are limited to only once in a two-year period. Charges for bite wing X-rays are covered only once every six months.

F. Benefits for crowns and inlays. These benefits are allowable only when extensive coronal destruction is radiographically evident, or when it can be demonstrated by study models, and when a tooth is beyond restoration with amalgam or composit resins. Charges for crowns and gold inlays will be limited to the charges for silver, porcelain or other materials.

Charges for gold inlays in crowns are covered only if they are necessary to restore the structures of the teeth broken down by decay or injury. Charges for replacement of crowns or gold inlays are covered only if they are over five years old.

PRINCIPAL EXCLUSIONS

The following dental services are not included in the Plan:

A. Services and supplies partially or wholly cosmetic in nature.

B. Facings on pontics or crowns posterior to the second bicuspid, which are considered to be cosmetic.

C. Training in, or supplies used for, dietary counseling, oral hygiene, plaque control, oral physco-therapy instruction, chemical analysis and saliva.

D. Medical charges.

E. Hospitalization for oral surgery, setting of fractures and dislocations of jaws and bony impactions.

F. General anesthesia, except when medically necessary.

G. Loss and theft of dentures and bridgework.

H. Items which may be reimbursed by other insurance plans, in order to prevent double payments.

I. Treatment of malignancies.

J. Drugs not normally supplied in dental office dispensed for treatment of oral diseases.

K. Procedures, restorations and appliances to correct congenital or developmental malformations.

L. Services and supplies for treatment of injuries caused by war, whether declared or not, and by international armed conflict.

M. Services and supplies furnished in a US Government hospital.

N. Services and supplies which, in the opinion of the Plan and it's Dental Director, are not necessary to the Member's dental health.

COORDINATION OF BENEFITS

This provision will coordinate the dental benefits payable as described herein in the event that a Member has other dental coverage for which an employer makes contributions or payroll deductions, or any government or tax-supported program with similar benefits.

A. One of the two or more plans involved will be the Primary Plan and the other(s) will be Secondary. The Primary Plan will pay benefits first, without consideration of the other plan(s). The Secondary Plan(s) will then make up the difference of the total Allowable Expenses. No plan will pay more than it would have without this special provision.

B. In the case of coverage under Federal Medicare or similar governmental plans, the benefits will be taken into consideration and shall be considered the Primary Plan.

C. If a plan has no coordination of benefits provisions, then it will automatically become the Primary Plan. If more than one of the plans has this benefit, then the oldest plan will be the Primary one.

D. Allowable expenses are any usual, customary, necessary and reasonable expenses which qualify as covered dental charges under the Plan.

E. A claim determination period is a Plan year.

The effective date of this Amendment is January 1, 1987.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT PLAN that the provisions contained in the Plan Document and Amendment Number 4 thereto are acceptable and will be the basis for the administration of said Employer's Employee Benefit Program described therein.

SIGNED AT HEMET this 10th day of MARCH, 1987.

BY Steve Langley

TITLE DIRECTOR OF FINANCE

WITNESS:

Mary Lou Allender

AMENDMENT NUMBER 5

To the Plan Document of the

City of Hemet Employee Benefit Trust

The Plan Document of the City of Hemet Employee Benefit Trust is hereby amended to clarify eligibility for dental and vision coverages, as follows:

(1) All employees who were active employees (not retired) on January 1, 1987, have an effective dental/vision coverage date of January 1, 1987. Fire employees coverage began August 1, 1987.

(2) Employees who were retired prior to January 1, 1987, do not have dental or vision care coverages.

(3) Employees who retire on or after January 1, 1987, and who were enrolled in the dental/vision coverages at the time of their retirement will retain dental and vision coverages.

(4) Employees who enroll in the medical plan on or after January 1, 1987, have dental and visions coverages with an effective date as stated on the enrollment card

The effective date of this Amendment is January 1, 1987.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT TRUST that the provisions contained in the Plan Document and Amendment Number (1) thereto are acceptable and will be the basis for the administration of the Employer's employee benefit program described therein.

SIGNED AT Hemet this 11 day of Dec. 1987.

BY: _____

TITLE: Director of Finance

WITNESS:

_____

EXHIBIT "G"

RESOLUTION NO. 3209

EXHIBIT H

AMENDMENT NUMBER 6

To the Plan Document of the

City of Hemet Employee Benefit Trust

The Plan Document of the City of Hemet Employee Benefit Trust is hereby amended to add the following Cost Management Program:

Cost Management Program

This program of benefits and services is designed to encourage Covered Persons to obtain quality medical care through the most cost-effective sources.

The Plan requires prior authorization for all Hospital admissions. This program is administered by ***ALTA REVIEW*** (also referred to as the Utilization Review Organization) and will assist in controlling costs by:

confirming the need for all non-emergency Hospital admissions;

approving the number of days of confinement, if hospitalization is required;

reviewing Physician and Hospital charges.

Hospital Pre-Admission Review

A Covered Person or attending Physician is required to call ***ALTA REVIEW*** as soon as a Hospital admission is scheduled or at least two working days prior to a scheduled admission (see exception for Emergency Hospitalizations below). Clinical information regarding the proposed admission will be discussed between the attending Physician and the Utilization Review Organization.

If the Utilization Review Organization determines that the Hospital admission is Medically Necessary, a length of stay will be assigned. The approved length of stay will be communicated, in writing, to the Physician, the Hospital, the Covered Person and the Contract Administrator.

The *ALTA REVIEW* toll-free number is 1-800-922-3029

Emergency hospitalizations will not require prior notification to the Utilization Review Organization but must be communicated to that organization within two (2) working days following admission.

Should the attending Physician determine that a confinement must be extended beyond the approved length of stay, an approval of extended days must be obtained from the Utilization Review Organization prior to extending the confinement.

The effective date of this Amendment is August 1, 1988.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT TRUST that the provisions contained in the Plan Document and Amendment Number (6) thereto are acceptable and will be the basis for the administration of the Employer's employee benefit program described therein.

SIGNED AT _____ this 30 day of Aug. 1988

BY: _____

TITLE: Director of Finance

WITNESS:

_____

EXHIBIT "H"

RESOLUTION NO. 3209

EXHIBIT I

AMENDMENT NUMBER 7

To the Plan Document of the

City of Hemet Employee Benefit Trust

The Plan Document of the City of Hemet Employee Benefit Trust is hereby amended to delete the ***ALTA REVIEW*** Cost Management Program which was added to the Plan by Amendment No. 6.

The effective date of this Amendment is January 1, 1989.

IT IS AGREED BY THE CITY OF HEMET EMPLOYEE BENEFIT TRUST that the provisions contained in the Plan Document and Amendment Number (7) thereto are acceptable and will be the basis for the administration of the Employer's employee benefit program described therein.

SIGNED AT _____ this 23 day of Dec, 1988

BY: Steve Langley

TITLE: DIRECTOR OF FINANCE

WITNESS:

_____

EXHIBIT "I"

RESOLUTION NO. 3209

EXHIBIT J

AMENDMENT #8

to the Plan Document of

City of Hemet

The City of Hemet Group Medical Plan is hereby amended as follows:

Page 6, section C

The following provision has been added:

> If you or your dependents are not enrolled within 60 days of the date you become eligible, you may enroll in this plan during the annual open enrollment only.

Page 9

The following provision has been changed in the *Schedule of Medical Benefits* Physician Home and Office Visits:

> After $20 deductible, 100% for illness.

The effective date of this Amendment is January 1, 1990.

It is understood and agreed by the City of Hemet that the above stated amendments and the provisions contained in the Medical Plan Document as amended herein are acceptable and will be the basis for the administration of the City of Hemet Group Medical Plan until otherwise rescinded in writing by the plan administrator.

SIGNED AT HEMET this 29 day of JAN, 1990

BY: Steve Jemigh

TITLE: DIRECTOR OF FINANCE

WITNESS: _____

EXHIBIT "J"

HARBOR INSURANCE COMPANY
does hereby accept Plan Change
No. 8 effective 01-01-90
By: _____

RESOLUTION NO. 3209

EXHIBIT K

AMENDMENT #9

to #4 of the Plan Document of

City of Hemet

Amendment #4 of The City of Hemet Group Medical Plan, Maximum Benefit Payable is hereby amended as follows:

The Maximum Benefit Payable has changed to the following:

$300 per calendar year per family

The effective date of this Amendment is January 1, 1990.

It is understood and agreed by the City of Hemet that the above stated amendments and the provisions contained in the Medical Plan Document as amended herein are acceptable and will be the basis for the administration of the City of Hemet Group Medical Plan until otherwise rescinded in writing by the plan administrator.

SIGNED AT HEMET this 29 day of JAN, 1990

BY: [signature]

TITLE: DIRECTOR OF FINANCE

WITNESS: _____

EXHIBIT "K"

AMENDMENT #10

to the Plan Document of

City of Hemet

The City of Hemet Group Medical Plan is hereby amended as follows:

The following provision has been added:

PRESCRIPTION DRUG PLAN

About Your Prescription Drug Benefits

The prescription drug program is an independent program, separate from the regular medical plan and administered by Prescription Card Service (PCS). You must refer to the PCS plan for a complete description of covered and not covered expenses.

The PCS plan provides benefits only for drugs or medicines prescribed by a *physician* but not to exceed a 34 day supply or 100 unit doses, whichever is greater.

The prescription drug benefit cannot be assigned regardless of the assignment provision in Other Important Plan Provisions.

Participating Pharmacy

The plan provides benefits only for a participating pharmacy's wholesale cost plus dispensing fee. A participating pharmacy is a pharmacy which has entered into a prescription drug plan agreement with PCS.

Non-Participating Pharmacy

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* of a participating pharmacy.

Deductibles

A deductible is the amount of covered expenses you must pay for each prescription before the plan will make payments. The PCS deductible does not accumulate toward any other plan deductible.

The deductible amount for the PCS plan is $_____ per generic prescription and $_____ for each brand name prescription.

The effective date of this Amendment is August 1, 1989.

It is understood and agreed by the City of Hemet that the above stated amendments and the provisions contained in the Medical Plan Document as amended herein are acceptable and will be the basis for the administration of the City of Hemet Group Medical Plan until otherwise rescinded in writing by the plan administrator.

Director of Finance

EXHIBIT "L"

NOT COVERED UNDER THE INSURANCE AGREEMENT

RESOLUTION NO. 3209

EXHIBIT M

CITY OF HEMET EMPLOYEE BENEFIT PLAN
AMENDMENT 11

Effective August 11, 1992, the City of Hemet Employee Benefit Plan is hereby amended as follows:

Item 1

Community Care Network has contracted with the Plan Sponsor to provide physician services and supplies to covered persons at specific rates. Covered persons will have a choice of obtaining physician services and supplies from physicians participating in the Preferred Provider Organization (PPO Physicians) or any other covered physician of their choice (non-PPO Physicians).

Item 2

Community Care Network has contracted with the Plan Sponsor to provide Utilization Review for Inpatient Hospital and Chemical Dependency Recovery Service (CDRS) Programs. A "pre-admission review" should be performed before entering a hospital or CDRS program for any scheduled (non-emergency) admission.

Item 3

The BASIC BENEFITS section of the SCHEDULE OF BENEFITS is amended to provide 80% reimbursement instead of 100% reimbursement (except as otherwise noted in this Amendment) for covered services and supplies provided by physicians not participating in the PPO or at hospitals not participating in the PPO. Reimbursement will remain at 100% for covered services and supplies provided by PPO hospitals and physicians.

Item 4

The BASIC BENEFITS section of the SCHEDULE OF BENEFITS is amended as follows:

Physician Home & Office Benefits

PPO Providers	**100% for injury or life threatening illness.**
	100% for non-injury or non-life threatening illness after $50 calendar year deductible.

Physician Home & Office Benefits, cont'd

Non-PPO Providers	100% for injury or life threatening illness. 80% for non-injury or non-life threatening illness after a $50 calendar year deductible.

Item 5

The following is added to the INDIVIDUAL EFFECTIVE DATES section of DEFINITIONS:

f) When an eligible covered employee or dependent changes immediate status from 1) a covered employee to a dependent or, 2) a covered dependent to an employee, there will be continuity of coverage with no reapplication of the Plan preexisting condition clause or any other Plan waiting periods or limitations.

Item 6

The PHYSICIAN section of DEFINITIONS includes a person acting within the scope of his/her license as a Marriage/Family/Child Counselor (MFCC) upon referral by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Psychologist (PhD).

Item 7

Expenses for services and supplies for In-Patient and Out-Patient Mental/Nervous Care and Alcoholism and Drug Addiction and eliminated from the Plan as eligible expenses for covered individuals and replaced by Item 8 (below).

Item 8

Expenses for alcoholism, chemical dependency, and mental health care are provided for each covered individual as follows:

Maximum Benefit	-$25,000 per calendar year -$50,000 lifetime per individual
In-Patient	-Maximum of 30 days per year subject to overall yearly and lifetime maximum benefit.
Hospital Charges: Deductible Reimbursement	 -$1,000 per ea hospitalization -80% of Usual, Reasonable and Customary charges

In-Patient, cont'd

Physician Charges:	
Deductible	-$50
Reimbursement	-80% of Usual, Reasonable and Customary charges
Out-Patient	-Maximum of 52 visits per year subject to overall yearly and lifetime maximum benefit
Physician Charges:	
Deductible	-$50
Reimbursement	-100% of Usual, Reasonable and Customary charges

Eligible services and expenses are subject to all other provisions and definitions of the Plan Document.

Item 9

Any charges for the treatment of temporomandibular joint dysfunction syndrome (TMJ) or any treatment of conditions caused by malocclusions or misalignment of teeth are excluded from the Dental Plan and the Basic Benefits section of the Medical Plan.

Charges for the treatment of any temporomandibular joint dysfunction syndrome (TMJ) or any treatment of conditions caused by malocclusions or misalignment of teeth are covered by the Major Medical section of the Medical Plan subject to an overall lifetime maximum benefit of fifteen hundred dollars ($1,500).

Item 10

PREVENTATIVE CARE is added to the BASIC BENEFITS SECTION of the MEDICAL PLAN as follows:

Preventative Care

Well Child Care through age two (2) subject to Basic Medical and Major Medical Plan provisions for all other treatment.

Infant and child immunizations through 12 years of age with a maximum benefit of $150 per calendar year.

Item 11

Vision Care Benefits are as follows:

When vision care is prescribed by a physician, a covered employee will be paid a Vision Care Benefit for reimbursement of covered vision care charges.

Covered vision care charges include only the charges of a licensed optometrist or ophthalmologist for supplies and service of Vision Care Procedures, up to the applicable Maximum Allowance rendered during the applicable benefit period for Vision Care Benefit.

No Vision Care Benefits shall be payable for:

1) Replacement of existing lenses more than once per year per individual;

2) Replacement of frames more than once in a two year period per individual;

3) Eye examinations more frequently than once per year per individual;

4) Eye examinations required by 1) an employer as a condition of employment, which the employer required to provide pursuant to an Agreement; or 2) a governmental body.

5) Supplies provided or services rendered in connection with 1) special procedures such as orthoptics or vision training; or 2) medical or surgical treatment;

6) Any service or supplies which are covered under any other plan of coverage of the employer;

7) Tinting of lenses beyond Level Two (2).

SCHEDULE OF VISION CARE PROCEDURES

Maximum benefit per family per calendar year	$300
Deductible amount	NONE
Reimbursement	100%
Carry Over- amount of unused benefits that may be carried over from one year to the next- up to	$300

(Lenses include, single vision, bi-focal, tri-focal and contact lenses).

Item 12

Any covered individual who is otherwise eligible for maternity benefits and who is pregnant as of August 11, 1992 or is actively under treatment for cancer prior to August 11, 1992 is entitled to reimbursement for expenses for treatment and supplies in connection with that pregnancy or cancer treatment on the basis of the plan benefits in place prior to August 11, 1992.

Item 13

Current chiropractic and physical therapy benefits will be retained, but limit chiropractic care to a maximum of $1500 per calendar year.

IT IS AGREED BY THE CITY OF HEMET BENEFIT PLAN that the provisions contained in the Plan Document and Amendment Number 11 thereto are acceptable and will be the basis for the administration of the Employer's employee benefit plan described therein.

SIGNED AT HEMET, CALIFORNIA this 11th day of August, 1992

BY:_____

TITLE:_____

WITNESS:

_____

RESOLUTION NO. 3209

EXHIBIT N

PROPOSED
CITY OF HEMET
POLICIES AND PROCEDURES

REVISION DATE: June 27, 1990
SUBJECT: Retirement Benefits

APPROVED: July 24, 1990
Effective Date:

PURPOSE

To establish the policy, procedure, and responsibility for the retirement benefits of the City of Hemet employees, spouses, and dependents.

INTENT

This procedure shall apply to all management, miscellaneous, police and fire employees. The policy covers currently retired employees and their spouses, all active employees and their spouses, all disabled employees and their spouses, surviving spouses and early retirees. The intent is to provide all employees with a source for medical benefits on a consistent and cost efficient basis during their retirement years, subject to the rights that the City reserves to change benefits, contributions, or financial vehicles for the delivery of these services over the years (such as self funding, carriers, HMOs, PPOs or other cost-containment vehicles that may be implemented).

PROCEDURE

1. Eligibility (normal service) - A length of service requirement and a minimum age requirement are an integral part of the medical benefits for all retirees. Upon leaving the City of Hemet, the retiree must be able to qualify for a normal service retirement benefit with the Public Employees Retirement System (PERS). The employee must be 50 years of age and have worked full time for the City of Hemet for a minimum of five years. The City shall provide the medical benefit program to all retirees so long as the employee or surviving spouse continues to be eligible for PERS retirement benefits. Should the retiree or surviving spouse elect to drop coverage, for any reason, the retiree (or surviving spouse) will not be re-enrolled.

2. Eligibility (disability) - To be eligible, the employee shall have worked full-time for the City of Hemet a minimum of five years and have been approved by the City of Hemet and PERS for a disability retirement. The employee will be included in the retiree plan until the final decision by PERS is made providing the minimum years of service requirement has been met upon applica-

tion date. The City shall provide the medical benefit program to all disability retirees so long as the employee or surviving spouse continues to be eligible for PERS retirement benefits and the employee is not gainfully employed as defined by the Social Security system or defined as follows, whichever provides a greater income: salary and wages from all sources including consulting fees, commissions, etc. in an amount which when added to the disability pension is greater than 100% of the current salary for the position from which the employee retired. This provision is not intended to apply to employees who are eligible for normal service retirement at the time of taking a disability retirement.

3. Schedule of Contributions - The City will contribute to the medical premiums over the lifetime of the retiree in accordance with the schedule below and as provided in Section 8 below.

PERCENT PAID BY THE EMPLOYER

Years of Service With City of Hemet	Employee/Spouse & Dependent Children
0-5	-0-
Over 5	25% + 7.5% for each year over 5

4. Medical Benefits - The City currently self funds and purchases medical benefits for active and retired employees. The City reserves the right to alter the medical plan design to provide the most efficient delivery system to the retirees. This includes, but is not limited to, changing the deductibles, co-insurance, cost containment provisions, second opinions, out-patient benefits, preferred providers, utilization reviews, etc. In the event that proposed alterations require the City to meet and confer with employee bargaining groups, the City will notify affected retirees of proposed changes.

5. Medicare - At age 65, or when eligible, all retirees will be required to enroll in the Medicare program, Part A and B, and benefits will be coordinated as a condition of enrollment in the City plan. Medicare will be an integral part of the plan design for payment of benefits and will provide secondary coverage with the City plan providing primary coverage.

6. Grandfather Clause - For employees hired, but not retired, prior to June 30, 1990, and their spouses, the City will contribute 100% of medical premiums in accordance with Section 8 of this policy for both normal service and disability retirements irrespective of the number of years employed by the City. For employees retired prior to June 30, 1990, and their spouses, the City will continue to contribute 100% of the medical premiums regardless of the plan selected.

7. Coordination of Benefits - The City's retiree plan will be secondary to all other group plans available to the retiree and will be coordinated with any medical group plans available to the retiree and spouse in accordance with applicable insurance law. The intent is to reimburse no more than 100% of the medical charges of the retiree, spouse, and dependents.

8. Calculation of monthly contributions - Except as provided in Section 6 above, the contribution to the retiree's medical plan will be the current premium contribution to the self-funded plan as determined by the City of Hemet or the rate set by memoranda of understanding which would affect the retiree if he were actively employed by the city, whichever is lower. The City reserves the right to alter the premium contribution to an amount that may be lower than the current rate, without setting a precedent for future years. The responsibility for the calculation of the contribution and its collection from the retiree will rest with the city Finance Department. In the event that proposed alterations require the City to meet and confer with employee bargaining groups, the City will notify affected retirees of proposed changes.

9. Surviving Spouse and dependent coverage - Coverage for the surviving spouse and family will be provided by the City so long as PERS 1957 or 1959 retirement benefits continue. Should the surviving spouse's PERS benefits be withdrawn or terminated, the City's paid medical benefits will also terminate. Medical coverage for surviving spouse and dependents will cease should spouse remarry.

   For a spouse to be eligible for coverage the marriage date must be not less than one year prior to the date of retirement. The employee may be required to provide (a copy of the marriage certificate may be required) to the Personnel Department to be eligible for spouse coverage.

A copy of a birth certificate may be required for dependent coverage. If the dependent is disabled, a doctor's statement may be required. Subsequent proof of disability will be required periodically as determined by the City and/or the carrier. A dependent may elect to drop coverage at any time but in such event, may not be re-enrolled later.

10. Employee Payments - The monthly contributions for the employee's share shall be billed in advance by the City on the first of each month and will be delinquent on the 15th. Non-payment for two successive months may result in cancellation of coverage. Upon cancellation re-enrollment shall be at the discretion of the medical insurance carrier and the City of Hemet.

11. Plan-to-Plan Transfers - Upon retirement the retiree may transfer from plan to plan during an open enrollment period if accepted by the provider. Retirees electing to enroll in the city-funded program will be required to provide a health certificate or other medical information in order to determine eligibility to join the city plan.

12. Meet and Confer - Prior to modifying this policy the City will meet and confer with employee organizations to whom this policy applies.

RICHARDS, WATSON & GERSHON
ATTORNEYS AT LAW
A PROFESSIONAL CORPORATION

GLENN R. WATSON
ROBERT G. BEVERLY
HARRY L. GERSHON
DOUGLAS W. ARGUE
MARK L. LAMKEN
ARNOLD SIMON
ERWIN E. ADLER
CAROLD D. PIEPER
ALLEN E. BENNETT
STEVEN L. DORSEY
WILLIAM L. STRAUBZ
ROBERT M. GOLDFRIED
ANTHONY S. DREWRY
MITCHELL E. ABBOTT
TIMOTHY L. NEUFELD
GREGORY W. STEPANICICH
ROCHELLE BROWNE
DONALD STERN
MICHAEL JENKINS
WILLIAM B. RUDELL
DAVID L. COHEN
QUINN M. BARROW
CAROL W. LYNCH
JEFFREY A. RABIN
GREGORY M. KUNERT
THOMAS M. JIMBO
MICHELLE BEAL BAGNERIS
AMANDA F. SUSSKIND
ROBERT C. CECCON
SAYRE WEAVER

STEVEN H. KAUFMANN
GARY E. GANS
JOHN J. HARRIS
KEVIN G. ENNIS
ROBIN D. HARRIS
MICHAEL ESTRADA
LAURENCE S. WIENER
C. EDWARD DILKES
STEVEN R. ORR
DEBORAH R. HAKMAN
SCOTT K. SHINTANI
MICHAEL G. COLANTUONO
TERRY P. KAUFMANN MACIAS
B. TILDEN KIM
RUBIN D. WEINER
SASKIA T. ASAMURA
KAYSER O. SUME
CRAIG A. STEELE
T. PETER PIERCE
ALISON E. MAKER
BENJAMIN BARNOUW
TERENCE R. BOGA
DOUGLAS A. CARLEN
DANIEL L. PINES
LISA MARIE BOND
WINNIE TSIEN
JENNIFER L. HART
DIANE ARKOW
ROXANNE M. DIAZ

RICHARD RICHARDS
(1918-1998)

THIRTY-EIGHTH FLOOR
333 SOUTH HOPE STREET
LOS ANGELES, CALIFORNIA 90071-1469
(213) 626-8484
FACSIMILE (213) 626-0078

OF COUNSEL
WILLIAM K. KRAMER

January 22, 1996

1171513
OUR FILE NUMBER
10810-00001

Mr. Robert T. Henderson
City Attorney
City of Hemet
450 East Latham Avenue
Hemet, California 92543

Reference: Analysis of City's Health Insurance Retirement Benefit Program.

Dear Mr. Henderson:

We have completed our supplemental analysis of the health insurance benefit program for retirees of the City of Hemet.

Your initial request was that we analyze whether the adoption of Resolution No. 2084 of the City Council, implementing a self-funded insurance plan, created vested health insurance benefits in City retirees. By letter dated November 29, 1995, we concluded that Resolution No. 2084 would likely be interpreted as committing the City to pay health insurance benefits for retirees at a rate equal to that of current employees. Under that interpretation, we concluded that the health insurance benefits of City retirees could fluctuate (up or down) with the level of benefits provided to current employees.

Since the date of that letter, we have learned additional historical facts which lead us to conclude that Resolution No. 2084 had a more limited purpose. We now conclude that Resolution No. 2084 was only intended to clarify that employees who had retired by the time of its adoption -- and who were already receiving full medical coverage -- would be eligible to participate in the new self-funded insurance plan.

After further discussions with you, we expanded the scope of our analysis to determine whether the City's practice of granting full medical coverage for health insurance benefits to retirees may have created vested rights to receive that benefit.

In Part I of this letter we set forth our understanding of all relevant facts. These facts were derived from our review of the materials which you provided to us and from telephone conversations with you. If we have misunderstood any of these facts, please so notify us as it may change the views and conclusions expressed herein.

In Part II we provide a brief discussion of the principles of law which we believe control this field. In Part III we set forth the analysis leading to the conclusion that Resolution No. 2084 was not intended to create vested rights in any retirees.

In Part IV, we analyze whether, independent of the adoption of Resolution No. 2084, the continuing historical practice of granting full coverage for health insurance benefits to retirees created an implied agreement by the City to provide such health insurance benefits. Based upon the facts presented to us, we believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that the City impliedly agreed to provide full coverage under the self-funded insurance plan for retirees who were otherwise eligible employees hired prior to the statement of policy made in 1990 at the levels in effect during their employment.

Finally, in Part V we discuss the scope of the City's authority to modify health insurance benefits previously granted to retirees. The sparse case law in this area indicates the City must offset any disadvantageous modifications with comparable new advantages.

I. Factual Summary.

In 1969, the City joined the Public Employees' Retirement System to obtain the benefits of the Meyers-Geddes State Employees' Medical and Hospital Care Act. It appears that the City paid the entire cost of enrollment for both employees and retirees. A file memorandum dated March 9, 1982, from Mr. Steve Temple to the City Manager states "[the City's] program with the State of California required that we provide paid coverage for the City's retired employees." Thus, the City apparently committed to provide equal coverage for employees and retirees no later than 1969. Prior to 1969, the City purchased

private health insurance for its employees through Blue Shield. The City Council minutes of February 10, 1958, refer to a portion of the premium being paid by individual employees. This appears to be the only instance of the City not paying 100 percent of the cost of insurance coverage. Other documents further suggest that the cost of coverage under the Meyers-Geddes plan increased at certain times and that the City continued paying the full cost of coverage.

In 1981, the City withdrew from the Meyers-Geddes plan and began forming a self-funded insurance plan. In his memorandum dated March 9, 1982, Mr. Temple noted the following:

> "Retired employees and existing employees have a vested commitment by the City to provide paid medical coverage. However, all future employees should be hired under a program established by a new Council policy." (Emphasis added.)

However, no resolutions, minute orders or policy statements were adopted by the City Council which reflected that commitment. Similarly, no policy manuals or flyers identifying such benefits were ever issued by the City.

On March 9, 1982, the City adopted Resolution No. 2084, to create a self-funded insurance plan. Section 2 of the Resolution provides:

> "The self-funded medical plan will continue to provide paid medical coverage for employees who have retired from the City of Hemet at the full time regular employee rate."

The minutes of the City Council meeting of that date indicate Section 2 was modified to delete the words "and will retire" from the proposed draft of Resolution No. 2084. Based on the blank space in that Section, we presume the proposed resolution originally intended to provide coverage to "employees who have retired and will retire . . . ."

Apparently, no formal declaration of policy relating to health insurance benefits for retirees was adopted by the City in 1982. The City increased the benefits under the self-funded insurance plan several times in subsequent years. Among other changes, the City added vision and dental coverage and reduced the plan deductible.

In 1990, the City apparently adopted a formal guide of "Policies and Procedures."[1/] The guide contains a "Grandfather Clause," which provides:

> "For employees hired, but not retired, prior to June 30, 1990, and their spouses, the City will contribute 100% of medical premiums in accordance with Section 8 of this policy for both normal service and disability retirements provided that the employee meets the eligibility requirements. For employees retired prior to June 30, 1990, and their spouses, the City will continue to contribute 100% of the medical premiums regardless of the plan selected." (Emphasis original.)

Section 8 of the guide states that the City's contribution will be the lower of: (i) the City's contribution rate for the self-funded insurance plan; or (ii) a rate set in the City's collective bargaining Memorandum of Understanding. The rate set in the Memorandum of Understanding apparently was never set lower than the self-funded rate.

The City's self-funded insurance plan contains a specific schedule of benefits which sets the level of coverage for each participant. The City made a contribution for each employee in order to defray the expenses of the plan. The level of contribution, however, appears to place no limitation on the plan's benefits. Thus, an employee was apparently entitled to full coverage under the plan regardless of whether the City's contributions to the fund were sufficient to cover expenses. The City apparently treated the expense under the self-funded insurance plan as an obligation of the City and the plan operated at a deficit at the end of its term.

In September of 1994, the City discontinued its self-funded insurance plan. The City replaced coverage with two HMO's from Aetna Insurance Company. Participants may chose from these plans or a Kaiser Permanente plan. However, it appears that participants which live outside the Kaiser service area must chose one of the HMO's.

In addition to the foregoing, Resolution No. 3119, adopted by the City on September 13, 1994, eliminated several employment positions. That Resolution specifically provides for the continuation of medical benefits to the eliminated employees.

1/ The copy of this document provided to us indicates in the upper right-hand corner that it was "Approved: 7-24-90." We have assumed that the guide was appropriately implemented and was distributed to City employees and retirees.

Resolution No. 3119 states that employees who retire as a result of the reduction in force will be entitled to "[f]ully paid health insurance in accordance with pertinent city policy for themselves and current dependents."[2/]

There apparently are no other City resolutions, minute orders or official statements of policy relevant to City retiree health insurance benefits. The City apparently has never distributed any manuals or other literature describing such benefits for retirees.

II. Summary of California Law.

Under California law, employees may acquire vested rights in deferred elements of their compensation. In Betts v. Board of Administration, 21 Cal.3d 859 (1978), the California Supreme Court summarized this rule as it applies to pensions by stating:

> "A public employee's pension constitutes an element of compensation, and a vested contractual right to pension benefits accrues upon acceptance of employment. Such a pension right may not be destroyed, once vested, without impairing a contractual obligation of the employing public entity. (Kern v. City of Long Beach (1947)." Id., at 863.

The Betts court further noted that "[a]n employee's contractual pension expectations are measured by benefits which are in effect not only when employment commences, but which are thereafter conferred during the employee's subsequent tenure." Id., at 866. Thus, an employee may acquire a vested right in an increased level of deferred compensation granted during the course of employment.

Under California law, a vested right to deferred compensation does not necessarily guarantee a specific level of benefits. In Kern v. City of Long Beach 29 Cal.2d 848 (1947), the California Supreme Court held as follows:

> "[A]n employee may acquire a vested contractual right to a pension but . . . this right is not rigidly fixed by the specific terms of the legislation in

---

2/ Similarly, employees who chose not to retire are also entitled to "[f]ully paid health insurance to the same extent as if such employees were eligible to retire under pertinent city policies, which health insurance shall be for the benefit of themselves and their current dependents."

> effect during any particular period in which he serves. The statutory language is subject to the implied qualification that the governing body may make modifications and changes in the system. The employee does not have a right to any fixed or definite benefits, but only to a substantial or reasonable pension. There is no inconsistency therefore in holding that he has a vested right to a pension but that the amount, terms and conditions of the benefits may be altered." Id., at 855.

An employer is, therefore, allowed some freedom in adjusting deferred compensation.

California courts, however, have placed strict limits upon an employer's right to alter the terms of deferred compensation. In Abbott v. City of Los Angeles 50 Cal.2d 438 (1958), the California Supreme Court summarized these limitations as follows:

> "'An employee's vested contractual pension rights may be modified prior to retirement for the purpose of keeping a pension system flexible to permit adjustments in accord with changing conditions and at the same time maintain the integrity of the system. [Citations] Such modifications must be reasonable, and it is for the courts to determine upon the facts of each case what constitutes a permissible change. To be sustained as reasonable, alterations of employees' pension rights must bear some material relation to the theory of a pension system and its successful operation, and changes in a pension plan which result in disadvantage to employees should be accompanied by comparable new advantages. [Citations.]'" Id., at 447, 448. (Citing Allen v. City of Long Beach 45 Cal.2d 128 (1955)).

California courts have applied the foregoing rules developed in the pension context to other forms of deferred compensation. In California League of City Employee Associations v. Palos Verdes Library District, 87 Cal.App.3d 135 (1978), the Court of Appeal affirmed a finding that vested rights accrued from a local agency's policy providing:

> "(1) a longevity salary increase, equal to 2 percent of base pay, awarded at the end of the 9th, 12th, 15th and 18th years of service; (2) a 5th week of vacation for full-time professional employees after 10 years of continuous service; and (3) a 4-month fully paid sabbatical for librarians at the end of each 6 years of full-time service." Id.

In so ruling, the Court of Appeal noted that " . . . the trial court was correct in the circumstances of this case in concluding that the benefits were important to the employees, had been an inducement to remain employed with the district, and were a form of compensation which had been earned by remaining in employment."

Similarly, in Thorning v. Hollister School District, 11 Cal.App.4th 1598 (1992), the Court of Appeal ruled that a school district board member had a vested right to retirement health insurance benefits implemented during his term of office. The court relied heavily upon the California League opinion, and ruled the benefits were vested deferred compensation:

> "[Retirement health insurance benefits] were included in District's official declaration of policy pertaining to remuneration and other benefits for board members. They were of importance to the board members as an inducement for their continued service on the board and as a factor in their decision to retire. Thus, under the criteria of California League, the benefits are fundamental and District may not unilaterally terminate them." Id., at 1607.

The ruling in Thorning, is consistent with a published opinion of the Attorney General finding that retirement health insurance benefits may become a vested element of compensation:

> "Based on the fundamental premise that the elements of compensation conferred during the term of public office become contractually vested [Citation omitted], such benefits conferred for life, in the nature of deferred compensation and as inducement for continued service, pursuant to an official declaration of policy may not be discontinued." 67 Ops.Cal.Atty.Gen. 510 (1984).

In short, retirement health insurance benefits have been considered by courts to be a substantial benefit which, when promised as an inducement to continued employment, can become a vested entitlement. Once vested, the employer may only modify the benefit to the extent the modification: (i) bears some material relation to the theory of a pension system; and (ii) provides comparable advantages to offset any disadvantages.

III. Construction of Resolution No. 2084.

As noted in the factual summary above, Section 2 of Resolution No. 2084 was originally drafted to read:

> "The self-funded medical plan will continue to provide paid medical coverage for employees who have retired and will retire from the City of Hemet at the full time regular employee rate."

The draft of Resolution No. 2084 as it was originally proposed to the City Council appears to contemplate a commitment to both past and future retirees.

The minutes of the City Council meeting during which Resolution No. 2084 was passed indicate that the proposed draft was amended to delete the terms "and will retire." This deletion strongly suggests that the City did not intend to make any commitment to future retirees. In Wilson v. City of Laguna Beach, 6 Cal.App.4th 543, 555 (1992), the Court of Appeal, interpreting State legislative history, notes that "[t]he rejection of a specific provision contained in an act as originally introduced is 'most persuasive' that the act should not be interpreted to include what was left out. [Citation omitted]." In short, we believe this deletion worked a substantive change in Resolution No. 2084 which cannot fairly be construed as granting vested rights to future retirees.

When read in context, it appears Resolution No. 2084 was intended solely as a clarification of the City's intention to grant previously retired individuals full coverage in the self-funded insurance plan. This raises a question as to whether or not the unilateral increase by the City was a constitutionally prohibited gift of public funds. In Nelson v. Los Angeles, 21 Cal.App.3d 916 (1971), the Court of Appeal held a City of Los Angeles charter amendment increasing the amount of pension benefits and the calculation of cost of living adjustments was constitutional. Based on its review of the law, the court noted:

> "Inherent in the statement of the settled principle is the rationale that an increase in pension benefits payable to a retired public employee or his widow on pensionable status is paid as the result of rights incident to that status and not as a matter of increased compensation or allowance." Id., at 919.

Based upon Nelson, the City was probably authorized to grant retirees full coverage under the self-funded insurance plan even though that act may have increased their benefits.

Our research further suggests that the City's declaration of intention to provide full coverage under the self-funded insurance plan could not create vested rights to such coverage for employees who retired prior to the adoption of Resolution No. 2084. Courts have based an employee's right to deferred compensation on the contractual theory that the benefit was given as an inducement to continued service. Retired employees, however, do not provide any additional services which could support such a "contract."

In Pasadena Police Officers Association v. City of Pasadena, 147 Cal. App. 3d 695 (1983), the Court of Appeal ruled the adoption of an increased benefit plan could not create vested rights in prior retirees. Retirees had by resolution been granted an uncapped cost of living adjustment. The City subsequently attempted to impose a cap on the adjustment to contain costs. As to employees who retired prior to the implementation of the initial cost of living adjustment, the court ruled:

> "Since these members had completed all their years of service and retired before any COLA benefit was enacted, they never gave services with the reasonable expectation that their pensions would be adjusted for changes in the cost of living. Thus, they had no vested contractual right, based on the contract in effect during their employment, to continuation of the COLA benefit." Id., at 706. (Citing Olson v. Cory, 27 Cal.3d 532, 542 (1980).[3/]

Similarly, in Claypool v. Wilson, 4 Cal. App. 4th 646, 663 (1992); cert. denied, 113 S.Ct. 812 (1992), the Court of Appeal held that "employees who ended their service prior to the enactment of the former supplemental Cola statutes have no vested right which could be impaired by their repeal."

In sum, we believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that Resolution No. 2084 is an expression of the intent of the City Council to include City retirees who retired prior to its adoption in the self-funded insurance plan. In the context of the revisions made by the City Council to the proposed Resolution No. 2084, we believe it unlikely that a court would construe it as making a commitment to future retirees. Applying Pasadena Police and Claypool, we further believe the City could

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3/ The court ultimately ruled that these employees had a right to a the cost of living adjustment on the basis of a separate contractual agreement.

present a strong argument that the adoption of Resolution No. 2084 alone did not create any vested rights in retirees who retired prior to its adoption.

IV. Impact of City's Practice of Granting Full Health Insurance Benefits to City Retirees.

We have also considered whether the custom and practice of the City with respect to health insurance benefits has created a vested right to those benefits. The vast majority of reported decisions in this area address claims where deferred compensation benefits were granted and modified pursuant to resolutions or charter amendments. In such cases, it is fairly easy for the employee to establish that the proposed benefit acted as an inducement to continued employment. In the case at hand, the City apparently has never adopted any resolutions setting forth an express policy with respect to health insurance benefits for retirees with the sole exception of Resolution No. 2084 discussed above.

In addition to resolutions and charter amendments, courts also have found that policy declarations such as employee manuals can alter the contract between a public entity and its employees in a variety of contexts. In Ivens v. Simon, 212 Cal.App.2d 177 (1963), the court ruled that a formal pay scale can become part of an employment contract. In Frates v. Burnett, 9 Cal.App.3d 63 (1970), the court held that rules and regulations adopted by a board of education can become a part of an employment contract. Likewise, in Healdsburg Police Officers Assoc. v. City of Healdsburg, 57 Cal.App.3d 444 (1976), the court ruled that a City could be equitably estopped to disclaim the terms of a policy manual even though the manual was not adopted by the city council.

Consistent with these cases, policy declarations may create vested rights in deferred compensation benefits. In Thorning, the court found a vested right where health insurance benefits were included in the school district's "official declaration of policy pertaining to remuneration and other benefits for board members." Id., at 1607. Similarly, in California League, the court ruled the library district's "Personnel Policies and Procedure" declaration created a right to the employment benefits described therein. We believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that the adoption of the "Policies and Procedures" guide in 1990, would constitute such a declaration and would create vested rights in employees hired after that date.

Absent a formal resolution or other declaration of policy, a vested right to retirement health insurance benefits could only arise prior to the statement of policy if it were legally implied from the conduct of the City. There are relatively few published opinions addressing claims that benefits were due under an implied contract. Nonetheless, in Youngman v. Nevada Irrigation District, 70 Cal. 2d 240 (1969), the California Supreme Court ruled a public employee could allege an entitlement to employment benefits based upon an implied agreement. The plaintiff in Youngman, alleged the Nevada Irrigation District maintained a five step wage scale system. Plaintiff further alleged:

> "[I]t was the 'announced practice' of the district to review each employee's situation annually and to advance the employee to the next step if his performance merited advancement." Id. at 245.

The plaintiff in Youngman also alleged that the implementation of the district's "announced practice" to grant wage increases created an implied promise to do so. The trial court, however, sustained a demurrer to the action.

On review, the Supreme Court concluded the plaintiff had alleged a legally cognizable claim of benefits. The court noted:

> "There seems little doubt that the general provisions giving the district the power to enter into contracts of employment without specifying any formal requirements for such contracts were intended to apply to both implied and express contracts since the only significant difference between the two is the evidentiary method by which proof of their existence and terms is established. Governmental subdivisions may be bound by an implied contract if there is no statutory prohibition against such arrangements." Id. at 246. (Emphasis added.)

The court in Youngman further noted the distinction between express and implied contracts lies in the "mode of proof." Id. The court noted the terms of an implied contract are determined by the parties' conduct. In so doing, it cited Civil Code Section 1621 which provides that "[a]n implied contract is one, the existence and terms of which are manifested by conduct." The court ruled the plaintiff's allegations, though sparse, alleged a viable claim. The court further observed as follows:

> "In pleading a cause of action on an agreement implied from conduct, only the facts from which the promise is

> implied must be alleged. (See 2 Chadbourn, Grossman & Van Alstyne, Cal. Pleading, @ 1011, p. 159.) Here the first cause of action alleges that the district had an 'announced practice' to grant annual wage increases, that this 'practice' was adopted 'after negotiation' with the IBEW, that the employees were aware of the 'practice,' and that the district had complied with its 'practice' in the prior year. While not a model of precise pleading, these allegations appear to set forth circumstances from which could be found an implied agreement, reached after negotiation with the IBEW, that the district would grant yearly increases. Therefore, the allegations of the first cause of action are sufficient to withstand a general demurrer." Id. at 246, 247.[4/]

The Youngman case, therefore, supports the proposition that the conduct of a public entity can create an implied contract for employee benefits.[5/]

Under Youngman, the City could be found to have created vested rights to health insurance benefits for its retirees if its conduct manifested an agreement to do so. Analyzing the potential for an implied agreement requires a highly fact specific inquiry. Here, the analysis necessarily requires a consideration of many facts beyond our knowledge, including: (i) the content of representations to employees during the hiring process; (ii) the content of negotiations with employee and retiree groups; and (iii) the representations made to retirees during the retirement process.

Notwithstanding this limitation, in our view the facts presented in the case at hand could be marshalled to make a strong argument for the existence of an implied agreement. Although the City never made an official declaration of policy

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4/ The Youngman opinion references the existence of "Personnel Policies," but fails to identify whether such policies were written. In either event, the existence of such policies does not appear to have influenced the court's holding.

5/ The court in California State Employees' Association v. Flournoy, 32 Cal.App.3d 219 (1973); cert. denied, 414 U.S. 1093 (1973), also recognized the implied contract theory as a potential basis for recovery. The Flournoy court ruled there was no implied contract to provide salary increases in that case because the public agency (University Regents) had no power to tax and, therefore, always required a legislative appropriation of funds to pay salary increases.

between 1969 and 1990, it appears to have conducted itself as if retirees were entitled to health insurance benefits:

1. In 1969, the City entered the Meyers-Geddes program which apparently required the City to provide retirees with health insurance benefits. The City appears to have fully paid the costs without ever explicitly reserving the right to discontinue the program.

2. In 1982, Mr. Temple's memorandum on implementing the self-funded insurance plan noted his understanding that "Retired employees and existing employees have a vested commitment by the City to provide paid medical coverage."

3. In 1982, when the City implemented the self-funded insurance plan by adopting Resolution No. 2084, it extended full health insurance benefits under the plan to all prior retirees. While the City made no specific commitment to future retirees, the City apparently granted full coverage to employees as they retired.

4. In 1990, when the City implemented a formal policy on retirement medical benefits, it included a "Grandfather Clause" which extended full health insurance benefits to all previously retired personnel and effectively committed to providing such coverage for individuals hired prior to the date of the policy.

5. In 1994, when the City implemented a reduction in force, it effectively provided retirement health insurance benefits to the dismissed employees.

In short, the City has consistently provided full health insurance benefits for retirees. There are apparently no facts which suggest that the City did not intend to grant full health insurance benefits to retirees. In light of the foregoing, we believe (although the matter is not entirely free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that the conduct of the City manifested an implied agreement that retirees would receive fully paid health insurance benefits.

Assuming then that employees otherwise eligible who were hired prior to the statement of policy in 1990 obtained vested rights to health insurance benefits upon retirement, the next question is what is the level of benefits. As noted above, the City made a contribution for each employee in order to defray the expenses of the self-funded insurance plan. The employee was apparently entitled to full health insurance benefits under the

plan regardless of whether the City's contributions were sufficient to cover expenses. A strong argument can be made that from the perspective of the employee the substance of the agreement was the entitlement to participate in the plan and to obtain the level of benefits provided therein.

The statement of policy made in 1990 contained a provision which confirmed that all prior retirees were entitled to a 100 percent contribution to the self-funded insurance plan. Based upon this expression of City policy we believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would likely conclude that a retiree was, at a minimum, entitled to the highest level of benefits available under the self-funded insurance plan during the employee's tenure. This would be consistent with the rule in Betts, that "[a]n employee's contractual pension expectations are measured by benefits which are in effect not only when employment commences, but which are thereafter conferred during the employee's subsequent tenure." Id., at 866.

V. Scope of Permissible Changes in Benefits Plan.

Under California law, a vested right in a deferred compensation benefit does not guarantee a specific benefit. Public entities retain an implied right to alter benefit plans so long as the beneficiary retains a "substantial or reasonable pension." Kern, supra, at 855. As noted in Abbott, supra, at 447, 448, reasonable alterations of pensions rights "must bear some material relation to the theory of a pension system and its successful operation, and changes in a pension plan which result in disadvantage to employees should be accompanied by comparable new advantages. . . '"

Relatively little case law has addressed the scope of permissible changes in benefit plans. In Wallace v. City of Fresno, 42 Cal.2d 180. 184 (1954), the California Supreme Court ruled the adoption of an amendment terminating pension rights upon conviction of a felony did not appear "to have any material relation to the theory of the pension system or to its successful operation." Thus, the court ruled such an amendment could not defeat vested pension rights.

In Claypool, supra, the court relied on Wallace and concluded that a pension modification "must relate to considerations internal to the pension system." The court noted

that a motive to save money does not render a modification invalid per se. The court stated:

> "Changes made to effect economies and save the employer money do 'bear some material relation to the theory of a pension system and its successful operation ....' [Citation omitted] That is not to say that a purpose to save the employer money is a sufficient justification for change. The change must be otherwise lawful and must provide comparable advantages to the employees whose contract rights are modified. We hold only that the monetary objective will not invalidate a modification which is otherwise valid." Id., at 666.

Based on this language, it appears a public entity may modify pension benefits to save money if any disadvantages are offset by comparable new advantages.

Courts have tended to analyze the effect on individual employees in determining whether a disadvantageous modification provides a comparable advantage. In Stork v. State of California, 62 Cal.App.3d 465 (1976), the Court of Appeal stated:

> "'[A]n advantage relied on as offsetting must relate generally to the benefit that has been diminished.' [Citation] Several California Supreme court decisions imply a necessity for inquiry into the alteration's practical impact upon the life situation of the individual employee before the court." Id. at 471.

The employee's job position in Stork was reclassified into a category of employees with incentives for early retirement. Although the employee would have received higher benefits for early retirement, he filed suit because he claimed his personal economic needs required him to continue working. The court ruled the reclassification was improper when viewed from the employee's perspective. The court stated that in context, "[t]he State's tender of a higher scale for early retirement of safety members supplies an illusory counterbalance." Id. at 472.

The court in California League adopted a similar approach. The library district in that case asserted that the elimination of three benefits was offset by a concurrent salary increase. The Court of Appeal rejected the argument, ruling in relevant part:

> "Furthermore, the court was not satisfied that the general salary increase could compensate in principle for the loss of a fifth week of vacation or the right to take a

> sabbatical leave. They constituted entirely different types of compensation. [Citation omitted.] In addition, the allegedly compensating salary increase fell unequally on different classes of employees, since only professionals (librarians) were entitled to the sabbatical and fifth week of vacation. Also, the employee who had already worked, say, nine years, or five and one-half years, lost much more benefits than one who had only worked one year toward qualifying for the longevity benefits, but both received the same salary increase. [Citation omitted.]" Id. at 141.

Both Stork and California League analyze the potential offset of disadvantages from the perspective of an individual employee. This standard would substantially limit the ability of a public entity to modify deferred compensation benefits since it must ensure that comparable advantages apply to all classes of beneficiaries. As a practical matter, this standard would make it difficult to unilaterally replace one form of benefit with another.

At least two courts have upheld modifications which tended to increase the solvency of the retirement plan. The retirement plan at issue in Houghton v. City of Long Beach, 164 Cal.App.2d 298 (1958), initially provided that benefits could only be paid from a fund calculated as two percent of the general tax levy. The City subsequently amended the plan to simultaneously convert the pension into a general obligation of the City, and to require employee contributions. The court upheld the amendment ruling "[t]he imposition of a member's contribution of two per cent (sic) of his salary toward a solvent fund, in substitution for an insolvent one, is 'a disadvantage' which is 'manifestly accompanied by comparable new advantages.'" Similarly, in Claypool, supra, at 669, the court upheld a modification in a cost of living adjustment program which substituted guaranteed actual benefits for "theoretical but illusory" higher benefits limited by a declining pool of funds.

Applying the foregoing rationale, and assuming both that (i) City employees otherwise eligible who were hired prior to the statement of policy made in 1990 obtained a vested right to full coverage under the self-funded insurance plan, and (ii) the City is not experiencing any severe financial crisis which would threaten the solvency of its current benefit plan, we believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that a substitution of the Aetna plans by the City would constitute an impermissible reduction of benefits. Although the motivation to save money does not render the substitution per se invalid, the

City must establish that any disadvantages have been offset by comparable new advantages.

VI. Conclusion.

The analysis of the obligations of the City to its retirees is complicated by the fact that the City operated its retirement program without an official declaration of policy until 1990. As a result, the terms of any agreement must be implied from the conduct of the City. It is not possible to accurately predict how a court would rule on this matter without conducting a substantial and thorough investigation into all of the practices of the City with respect to its employees and retirees.

Based upon the facts presented to us we believe (although the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that the City impliedly agreed to provide full coverage under the self-funded insurance plan for retirees who were otherwise eligible employees hired prior to the statement of policy made in 1990. We base our conclusion on those facts which indicate that the City continuously either granted or confirmed full coverage for retirees. In light of the declaration of policy granting full participation in the self-funded insurance plan contained in the statement of policy made in 1990, we also believe (again, however, the matter is not free from doubt in the absence of more specific statutory or judicial guidance) that it is more likely than not that a court would conclude that any vested right included a right to the level of coverage provided by that plan.

As for the ability of the City to modify health insurance benefits previously granted to retirees, the sparse case law in this area indicates that the City must offset any disadvantageous reduction in benefits with a comparable new advantage.

If you have any further questions regarding this matter, please do not hesitate to contact us.

Very truly yours,

William L. Strausz

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