SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

123

FROM: Human Resources

SUBMITTAL DATE:
March 1, 2012

SUBJECT: 2012 Voluntary Employees' Beneficiary Association Post Employment Program Health Savings Plan – Amended Plan Summary, Amended and Restated Plan Document

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the County's Voluntary Employees' Beneficiary Association (VEBA) Post Employment Program (PEP) Health Savings Plan (HSP) Amended and Restated Plan Document (Attachment A), effective January 1, 2012, to reflect recent legislation and contract changes; 2) ratify and approve the Amended Plan Summary to reflect legislative changes and clarifications to improve the readability of the Summary (Attachment B); 3) authorize the chairperson to sign four (4) copies of Attachment A; and 4) retain one (1) copy of the signed document and return three (3) copies of the signed documents to Human Resources for distribution.

BACKGROUND: The County of Riverside VEBA HSP was approved by the Board of Supervisors on November 26, 2002, and ratified on June 10, 2003. The VEBA HSP is designed to provide tax-free

S. Atin

Shawn Atin, Asst. Human Resources Director for
Barbara A. Olivier
Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 0	In Current Year Budget:	No
	Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	No
	Annual Net County Cost:	$ 0	For Fiscal Year:	2011/12

SOURCE OF FUNDS: Fees are paid by Plan participants – no additional cost to the County.

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

BY: Elizabeth J. Olson

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU DATE 3-7-12

Departmental Concurrence

☒ Policy ☐ Consent

☐ Policy ☐ Consent

Dep't Recomm.:

Per Exec. Ofc.:

Prev. Agn. Ref.: 01/10/12, 3.37; 11/26/02, 3.39

District: All

Agenda Number: 3.9

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

BACKGROUND (continued):

reimbursement for Internal Revenues Service (IRS) qualified medical expenses incurred by the participant and/or the participant's eligible dependents. Eligible expenses are detailed in IRS Publication 502 and include such items as the purchase of post employment health coverage (medical, dental, vision, etc.), copayments and deductibles. There are approximately 1,658 participants in the plan with assets totaling $21.8 million as of September 30, 2011.

On January 10, 2012, Item 3.37, the Board approved the VEBA HSP Agreements with VEBA Service Group, LLC (VSG) for consulting services, A.W. Rehn and Associates, Inc., (Rehn) for administrative recordkeeping and payment disbursement, and Washington Trust Bank to act as Trustee and Investment Manager for the Plan.

Listed below is a brief summary of the VEBA HSP Amended and Restated Plan Document and Plan Summary changes, effective, January 1, 2012:

Plan Document (Attachment A)

- Section 5.1 Medical Benefits: To comply with Section 125 Health Flexible Spending Act (FSA), language was added to disallow reimbursement of expenses incurred prior to becoming a Participant in the Plan and require participants with a Section 125 Health Flexible Spending Act (FSA) to exhaust their FSA reimbursement prior to filing claims against their VEBA HSP account.
- Section 5.1.2 Claims for Benefits: To include language allowing participants who separate from the County and subsequently return to employment to file claims for medical benefits that incurred on or after the date the participant separated from service.
- Section 5.1.3 Payment of Benefits: To coincide with the Professional Services Agreement with A.W. Rehn and Associates, Inc., eliminate direct payments to health care providers from VEBA HSP accounts; and limit reimbursement of medical benefits and premiums to participants directly.
- Section 6.3 Mechanics of Payment: To clarify language and limit reimbursement from the account to qualified reimbursable medical benefits and premiums that are incurred by a deceased participant (prior to death), their surviving spouse and any other dependents.
- Section 6.4 Claims Procedure: To comply with Section 2719 (Appeals Process) in the Patient Protection and Affordable Care Act (PPACA) language was added to update the internal and external claims appeal process to refine communication requirements and timeframes for the denial of a claim and information to initiate an appeal.

Plan Summary (Attachment B)

- Clarification of language to improve readability.
- Reimbursement Procedures - to coincide with the Plan Document changes.
- Claims Procedures - to coincide with the Plan Document changes required by legislation.

There is no cost to the County for the recommended action.

COUNTY OF RIVERSIDE
CALIFORNIAVOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
POST-EMPLOYMENT HEALTH SAVINGS PLAN
("VEBA HSP" or "Plan")

THIS PLAN is amended and restated by The County of Riverside, California ("Employer") for the benefit of its eligible Participants.

Article I.
Name, Documents & Definitions

1.1 Name. The name of this Plan shall be the County of Riverside, Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan ("Plan"). It is intended that the plan qualify as a Voluntary Employees' Beneficiary Association under Internal Revenue Code § 501(c)(9).

1.2 Plan Documents. This Plan, together with the Trust instrument, any applicable collective bargaining agreements, the Plan Summary, and the individual Enrollment Form, shall constitute the Plan documents.

1.3 Definitions.

1.3.1 "Administrator" means the County of Riverside.

1.3.2 "Dependent" means the Participant's spouse, dependent, or child (who as of the end of the taxable year has not attained age 27) as determined under IRC § 105(b).

1.3.3 "Disabled" means the Employee is eligible for California Public Employees' Retirement System disability retirement or Social Security disability payments.

1.3.4 "Effective Date" for this Plan document shall be January 1, 2012.

1.3.5 "Employee" means any current or former employee of the Employer, as defined by Treasury Regulation § 1.501(c)(9)-2(b).

1.3.6 "Employer" means the County of Riverside, California and, individually and collectively, any governmental entity affiliated with the County for purposes of Section 501(c)(9) of the IRC that maintains the Plan.

1.3.7 "Enrollment Form" means the form which may be used by the Employer when enrolling Participants.

1.3.8 "Fiduciaries" under this Plan are the Trustee and the Employer.

1.3.9 "IRC" means the Internal Revenue Code of 1986, as amended from time to time.

1.3.10 "Investment Account" means any investment account established by the Trustee to fund benefits under the Plan. The Trust's power to invest funds is described in the Trust instrument.

1.3.11 "Medical Benefits" means medical care expenses defined by IRC § 213(d) and IRC § 106(f) (for years to which IRC § 106(f) applies) and as described in Section 5.1.

1.3.12 "Participant" means a current or former Employee for whom Employer deposits have been received by the Trust and whose Participant Account has a positive balance.

1.3.13 "Participant Account" refers to the account maintained with respect to each Participant to record his/her share of the contributions of the Employer and adjustments relating thereto.

1.3.14 "Plan Year" is the calendar year except the first year for this Plan is the period from December 1, 2002 to December 31, 2002.

1.3.15 "Third-party Administrator" means an administrator appointed or contracted by the Employer from time to time to administer all or a portion of the Plan.

1.3.16 "Trust or Trust Instrument" refers to the Trust Agreement for the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan dated December 1, 2002 and effective until December 31, 2011, and thereafter refers to the Trust Agreement for the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan dated January 1, 2012.

1.3.17 "Trustee" refers to the bank serving as Trustee as appointed by the County of Riverside, California.

Article II.
Participation

2.1 In General. Subject to the limitations of Section 2.2, and subject to the eligibility provisions of Employer policies and applicable collective bargaining agreements, an Employee becomes a Participant under this Plan at the time of the first Employer deposit to this Plan on behalf of the Employee.

2.2 Limitations. This Plan does not permit any condition for eligibility or benefits which would discriminate in favor of any class of Participants to the extent such discrimination is prohibited by applicable law.

2.3 Duration of Participation. Once an Employee becomes a Participant in the Plan, his/her participation shall continue as long as funds remain in his/her Participant Account.

Article III.
Funding of Benefits

3.1 Deposits. The Employer shall deposit to this Plan on behalf of its eligible Employees on terms pursuant to collective bargaining agreements or Employer policies, whichever is applicable. Employer deposits shall be specifically allocated to appropriate Participant Accounts for the purpose of providing for payment of the benefits described hereinafter as set forth in any applicable collective bargaining agreements or Employer policies.

Article IV.
Participant Accounts

4.1 Participant Accounts. Accounting records shall be maintained by the Third-party Administrator to reflect that portion of the Trust with respect to each Participant, and the contributions, income, losses, increases and decreases for expenses or benefit payments attributable to each such account. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

4.2 Receipt of Deposits. Deposits for any Plan Year will be credited as received by the Trustee and are to be allocated as directed by the Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 Allocate and credit any Employer deposit to this Plan that is made during the month to a Participant Account within 2 business days of receipt of such contribution.

4.3.2 At the end of each month, adjust each Participant Account upward or downward, by an amount equal to the net income or loss accrued under this Plan by the Account; and

4.3.3 At the end of each month, charge to each Participant Account applicable fees, payments or distributions attributable to the Account or which are otherwise allocable to the Account that have not been charged previously.

Article V.
Medical Benefits

5.1 Medical Benefits. Medical Benefits must be payment or reimbursement for medical care benefits as defined by IRC §213 and limited by IRC § 106(f) where applicable and excludable from income under IRC §105 and 106, as amended from time to time. Reimbursements are limited to medical benefits not provided by Social Security, Medicare, or any other medical insurance contract or plan, and the payments or reimbursements may not be made for items paid or payable by any other insurance contract or plan, or for expenses that are deducted by the Participant under any section of the Internal Revenue Code, or for expenses which were incurred prior to becoming a Participant of the Plan.

Notwithstanding the penultimate sentence of the immediately preceding paragraph, Medical Benefits may include the payment or reimbursement of benefits otherwise

provided under an IRC §125 plan (frequently referred to as a 'flexible spending account') covering the particular Participant, but only to the extent that such payment or reimbursement was not made by that other plan and is ineligible for payment or reimbursement from that other plan because the amount available from that plan to that Participant has been exhausted.

Participants who are covered by an IRC § 125 health care flexible spending account which provides benefits covered under this Plan must exhaust benefits under the IRC § 125 plan prior to filing a request for reimbursement of Medical Benefits under this Plan.

5.1.1 Expenses. Medical Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s).

5.1.2 Claims for Benefits. Participants may file claims for Medical Benefits incurred on or after the date the Participant has separated from service with the Employer, provided that, before any claim may be submitted for reimbursement, the Third-party Administrator has received a completed and signed Enrollment Form and any additional information that, in the discretion of the Third-party Administrator, is required or necessary for the Plan to comply with applicable law, including without limitation, the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Participants who subsequently return to employment with the Employer may continue to file claims for Medical Benefits incurred on or after the date the Participant has separated from service with the Employer.

5.1.3 Payment of Benefits. Medical Benefits shall include but are not limited to Medical Benefits or premiums reimbursed directly to the participant or other person authorized pursuant to a court order or legal authorization. Reimbursements shall be made in accordance with rules and regulations established by the Third-party Administrator from time to time.

5.1.4 Dependent Medical Benefits in the Event of Death. If the Participant dies with a positive Participant Account balance, his/her surviving spouse, if any, may file claims for eligible Medical Benefits incurred by the Participant, the surviving spouse and any other Dependents. If a Participant dies without a surviving spouse and with Dependent(s), the guardian(s) of the Dependent(s) may file claims for eligible Medical Benefits on behalf of the Dependent(s). Upon the death of the last to die of the Participant, surviving spouse, or Dependent(s), the executor or administrator of the estate may file claims for any eligible Medical Benefits, after which any remaining account balance will be forfeited to the Plan.

5.2 Termination of Benefits. All benefits will terminate when the Participant's Account has no funds remaining.

Article VI.
General Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Medical Benefits, or to any Dependent for Medical Benefits in the event of the Participant's death under the Plan shall be limited to the balance in such Participant Account. Neither the County of Riverside,

California, its agents, officers, or employees, nor the Trustee or Third-party Administrator shall be responsible for any Medical Benefits under the Plan.

6.2 Investment of Participant Accounts. The Employer shall determine the options to be made available through the Trust for the investment of Participant Accounts, and each Participant shall elect one or more of the options. Participant elections shall be made and changed in accordance with procedures established by the Third-party Administrator and as may be amended from time to time. In the event no election has been made with respect to a Participant Account, that Account shall be invested in a default investment.

6.3 Mechanics of Payment. The Participant, or in the event of the Participant's death, a spouse or Dependent's guardian, or if no Dependent(s) remain eligible to file claims, the beneficiary determined under Section 5.1.4 may submit a request for eligible benefits to the Third-party Administrator for the Trustee:

6.3.1 To reimburse Medical Benefits for premium amounts paid to an insurance company, health maintenance organization, preferred provider organization or other eligible medical plan for qualified insurance premiums; or

6.3.2 To reimburse Medical Benefits for qualified COBRA premium payments; or

6.3.3 To reimburse out-of-pocket Medical Benefits.

6.4 Claims Procedure. A person claiming benefits under the Plan (referred to in this Section as the "claimant") shall deliver a request for such benefit in writing to the Third-party Administrator. The Third-party Administrator shall review the claimant's request for a Plan benefit and shall thereafter notify the claimant of its decision as follows:

6.4.1 If the claimant's request for benefits is approved by the Third-party Administrator, it shall proceed to direct the Trustee with respect to the distribution of such benefits, and notify the claimant of such approval and distribute such benefits to the claimant.

6.4.2 In the event the Third-party Administrator determines that a claim is questionable, the Third-party Administrator shall within fifteen (15) days from the date the claimant's request for Plan benefits was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said claim, provide the claimant with written notice of its need for additional information. In the event special circumstances require an extension of time for reviewing the claimant's request for benefits, the Third-party Administrator shall, prior to the expiration of the initial 15 day period referred to above, provide the claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Third-party Administrator expects to render its decision. In no event shall such extension exceed a period of thirty (30) days from the date of the expiration of the initial period, totaling forty-five (45) days at a maximum.

6.4.3 If the claimant's request for benefits is denied, in whole or in part, by the Third-party Administrator, the Third-party Administrator shall notify the claimant of such denial and shall include in such notice, set forth in a manner calculated to be understood by the claimant, the following:

6.4.3.1 The specific reason or reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meaning of these codes;

6.4.3.2 Specific reference to pertinent Plan provisions or IRS rules and regulations on which the denial is based;

6.4.3.3 A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

6.4.3.4 A description of available internal appeals processes, including information regarding how to initiate an appeal pursuant to Section 6.4.5 below.

6.4.4 In the event written notice of a denial of a request for benefits is not provided the claimant in the manner set forth in Section 6.4.3, the request shall be deemed denied as of the date on which the Third-party Administrator's time period for rendering its decision expires.

6.4.5 Any claimant whose request for benefits has been denied, in whole or in part, or such claimant's authorized representative, may appeal said denial of Plan benefits by submitting to the Third-party Administrator a written request for a review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than one hundred and eighty (180) days from the date the claimant received written notification of the Third-party Administrator's initial denial of the claimant's request for benefits or from the date the claim was deemed denied, unless the Third-party Administrator, upon the written application of the claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

6.4.6 During the period prescribed in Section 6.4.5 for filing a request for review of a denied claim, the Third-party Administrator shall permit the claimant to review pertinent documents and submit written issues and comments concerning the claimant's request for benefits.

6.4.7 Upon receiving a request by a claimant, or his authorized representative, for a review of a denied claim, the Third-party Administrator shall deliver the complete file to the Employer, who shall consider such request promptly, and shall advise the claimant of its decision within thirty (30) days from the date on which said request for review was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said denied claim. In the event special

circumstances require an extension of time for reviewing said denied claim, the Employer shall, prior to the expiration of the initial 30-day period referred to above, provide the claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Employer expects to render its decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the claimant's request for review was received by the Third-party Administrator. The Employer's decision shall be furnished to the claimant and shall:

6.4.7.1 Be written in a manner calculated to be understood by the claimant;

6.4.7.2 Include specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes; and

6.4.7.3 Include specific references to the pertinent Plan provisions or IRS rules on which the decision is based;

6.4.7.4 A description of available external review processes including information regarding how to initiate an appeal pursuant to paragraph 6.4.9 below; and

6.4.7.5 The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

6.4.8 The Employer may, in its discretion, determine that a hearing is required in order to properly consider the claimant's request for review of a denied claim. In the event the Employer determines that such hearing is required, such determination shall, in and of itself, constitute special circumstances permitting an extension of time in which to consider the claimant's request for review.

6.4.9 After exhausting the above claims procedures in full, any claimant whose request for benefits has been denied or deemed denied, in whole or in part, or such claimant's authorized representative, may file a request for an external review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than four (4) months from the date the claimant received written notification of the Third-party Administrator's final denial of the claimant's request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the Third-party Administrator must complete a preliminary review to determine if the claimant was covered under the Plan, the claimant provided all the information and forms necessary to process the external review, and the claimant has exhausted the internal appeals process.

Once the review above is complete, the Third-party Administrator has one (1) business day to notify the claimant in writing of the outcome of its review. If claimant

is not eligible for external review, the notice must include contact information for Employee Benefits Security Administration of the Department of Labor. If the claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four month filing period to complete the filing.

Upon satisfaction of the above requirements, the Third-party Administrator will provide that an independent review organization (IRO) will be assigned using a method of assignment that assures the independent and impartiality of the assignment process. Claimant may submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by the claimant to the Third-party Administrator within one (1) business day of receipt. The decision by the IRO is binding on the Plan, as well as the claimant, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the Third-party Administrator and the claimant of its decision to uphold or reverse the benefit denial within no more than forty-five (45) days. An expedited external review in certain circumstances is available and the IRO must provide notice as soon as possible but no later than seventy two (72) hours after receipt of the request.

6.4.10 The claims procedures set forth in this Article 6 shall be strictly adhered to by each Claimant under this Plan, and no judicial or arbitration proceedings with respect to any claim for Plan benefits hereunder shall be commenced by any such claimant until the proceedings set forth herein have been exhausted in full.

6.5 Protected Health Information. The Plan, Trustee and Third-party Administrator shall comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 with respect to protecting the privacy and security of protected health information.

Article VII.
Third-party Administrator

7.1 Rights & Duties. The Employer shall enforce this Plan in accordance with its terms and shall be charged with its general administration. The Employer may delegate administrative duties to the Third-party Administrator or other designee. The Third-party Administrator shall exercise all of its discretion in a uniform, nondiscriminatory manner and shall have all necessary power and discretion to accomplish those purposes, including but not limited to the power:

7.1.1 To determine all questions relating to the eligibility of Employees to participate in the Plan.

7.1.2 To determine entitlement to benefits under the provisions of Article 6.

7.1.3 To compute and certify to the Employer the amount and kind of benefits payable to the Participants.

7.1.4 To maintain all the necessary records for the administration of this Plan other than those maintained by the Employer or the Trustee.

7.1.5 To prepare and file or distribute all reports and notices required by law.

7.1.6 To authorize all the disbursements by the Trustee from the Trust.

7.1.7 To inform the Trustee of the Participants' elections with respect to the investment of Participant Accounts.

7.1.8 To make, publish and interpret such rules for the regulation of this Plan that are not inconsistent with the terms hereof.

7.1.9 If a Third-party Administrator has been named, it shall assume and perform each and every duty and responsibility delegated to it by the Employer and Trustee.

7.2 Information. To enable the Third-party Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions with respect to Participants and the Employee's eligibility to participate in the Plan and information relative to the Employee's termination of employment. The Third-party Administrator shall maintain such information and advise the Employer of such other information as may be pertinent to the administration of the Trust.

7.2.1 The Third-party Administrator shall forward to each Participant information relative to the Participant's Account and how to request payment of benefits. The information will include a summary of the Plan, including claim procedures and forms. The Third-party Administrator shall also mail a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial deposit, acknowledging establishment of the Participant's Account, confirmation of the amount received, a description of the Plan, and a toll-free contact telephone number and e-mail address for error corrections or questions.

7.2.2 The Third-party Administrator shall mail a written statement quarterly, or at any other time upon request, which shall include the following information: Participant's name and address; deposits received and the month the amount was posted to the Participant's Account; total Participant Account value at statement date; net income or loss and applicable fees, payments or disbursements attributable or allocable to the Participant Account; all payout and disbursement amounts, ending/forward balance; e-mail address and toll-free contact telephone number for error corrections or questions regarding the statement.

7.2.3 The Third-party Administrator shall provide a monthly unaudited report to the Employer including the following: income statement, balance sheet, number of

Participant Accounts, and other such reports which are permitted by law the Employer requests and agreed to by the Third-party Administrator.

7.3 Consultants, Investment Managers, Third-party Administrators, Lawyers & Accountants. The Employer may employ such consultants, investment managers, Third-party Administrators, lawyers and accountants, as it reasonably deems necessary or useful in carrying out administration of the Plan, the cost of which shall be considered expenses of administering the Plan.

7.4 Compensation & Expenses. Consultant and investment manager expenses for the Plan may be paid by reasonable reductions of investment earnings and/or assessments from the Participants Accounts as determined by the Employer from time to time. The Employer shall be responsible for all other necessary Plan expenses including but not limited to: legal, third-party administrator, auditing, printing, postage, mail service, Trustee, bank, consultant fees not paid by reduction of investment earnings, etc.

7.5 Liability Limitation. The County of Riverside, California, its agents, officers, or employees, and the Third-party Administrator shall not be liable for the acts or omissions to act of any investment manager appointed to manage the assets of the Plan and Trust. The Employer shall not be liable for the acts or omissions to act of any investment manager appointed to manage the assets of the Plan and Trust if the Employer in appointing such manager acted with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person would use in the conduct of an enterprise of a like character and with like aims.

7.6 Notices & Directions. The address for delivery of all communications shall be: the County of Riverside, California, 4080 Lemon Street, Riverside, CA 92502-1569, marked to the attention of the Human Resources Director.

7.7 Funding Policy & Procedures. The Employer shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and provisions required by applicable collective bargaining agreements and the provisions of applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employer that this Plan will be continued indefinitely, but continuance of this Plan is not assumed as a contractual obligation of the Employer. This Plan may be amended or terminated only as provided in this Article.

8.2 Exclusive Benefit Rule. It shall be impossible for any part of the assets under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants.

8.3 Amendments.

8.3.1 The Employer shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments, however, if such amendment affects the Trustee's duties or liabilities, the amendment will need the Trustee's written approval.

8.3.2 Such amendments shall be as set forth in an instrument in writing executed by the Employer. Any amendment may be current, retroactive, or prospective, in each case as provided therein.

8.4 Discontinuance of Contributions. The Employer shall have the right to discontinue contributions without prior notice unless otherwise required by law.

8.5 Termination of Plan. The Employer shall have the right to terminate this Plan without prior notice unless otherwise required by law. In case of termination, the Employer shall also notify the Trustee of the Employer's decision with regard to disposition of the assets, based on the following options:

a. A direct in-kind transfer of assets to a substantially similar IRC §501(c)(9) trust;

b. A series of installment payments over a period of time of the assets from the Trust attributable to this Plan to another IRC §501(c)(9) trust;

c. An immediate cash payment to another IRC §501(c)(9) trust or another program providing medical benefits for the Participants of this Plan, subject to any contractual adjustments due upon such a cash-out; or

d. Any other method permitted by IRC §501(c)(9).

Article IX.
Miscellaneous

9.1 The Trust. This Plan, the Trust, the Plan Summary, and the Enrollment Form are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of this Plan, the Plan Summary, the Enrollment Form and the Trust, such conflict shall be resolved by reference to the Plan document in the following order of priority: the Plan, then the Plan Summary, then the Enrollment Form, and then the Trust. The terms of the Plan document with the higher order of priority shall control with respect to any such conflict.

9.2 Applicable Law. This Plan shall be construed, administered, and governed under the laws of the State of California. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

9.3 Gender & Number. Words used in the masculine shall apply to the feminine where applicable, and vice versa, and when the context requires, the plural shall be read as the singular and singular as the plural.

9.4 Headings. Headings used in this Plan are inserted for convenience of reference only, and any conflict between such headings and the text shall be resolved in favor of the text.

9.5 Unclaimed Accounts. In the event any Participant Account shall have been unclaimed for a period of at least three (3) years since the whereabouts or continued existence of

the person entitled thereto was last known to the Third-party Administrator, and the Third-party Administrator determines that the whereabouts or continued existence of such person cannot reasonably be ascertained, the remaining balance in such Participant Account shall be forfeited to the Plan, as authorized under California Code of Civil Procedure section 1521, subdivision (b) and as limited by subdivision (c) if applicable, to pay operating expenses of the Plan and the Participant Account shall terminate.

9.6 Audit and Recordkeeping. The Employer shall have the right to conduct an audit of Plan income, expenses, investments, and accounts or to have such audit conducted by an audit firm of its choosing. Similarly, Plan records shall be available for inspection and review by any regulatory agencies authorized by law to do so. The Third-party Administrator, Trustee, Employer and all persons and entities retained by any of them to perform services with respect to the Plan shall (a) cooperate with any such audit, inspection or review, and (b) retain any records within their possession pertaining to the Plan for a period of at least seven (7) years in accordance with the Plan's Document Retention and Destruction Policy, unless they first offer to turn over such records to the County of Riverside prior to disposing of such records. This Section 9.6 shall survive the termination of this document and the termination of the Plan.

9.7 Limitation on Rights. Neither the establishment of this Plan, nor any modifications or amendment thereof, nor the making of any contributions to or the payment of any benefits from the Plan shall be construed as giving any Participant, or any person whomsoever, any legal or equitable right against the Trustee, the County of Riverside, California, its agents, officers and employees.

9.8 Assignment. The interest of any Participant, Dependent or beneficiary, in the Plan or assets or Participant Account held with respect to the Plan shall not be subject to assignment or alienation, either by voluntary or involuntary act of the Participant, Dependent or beneficiary or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process.

9.9 Counterparts. This Plan may be adopted in an original and any number of counterparts, each of which shall be deemed to be an original of one and the same instrument. IN

[The remainder of this page was intentionally left blank.]

IN WITNESS WHEREOF, the County of Riverside, California has executed this amended and restated Plan Document on _____.

COUNTY OF RIVERSIDE:

By: _____
Barbara A. Olivier
Asst. CEO / Human Resources Director

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

By: _____
Chairman, Board of Supervisors

Date: _____

Approved to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: _____

Title: Vice President

Address: P.O. Box 2127

Spokane, WA 99210-2127

ATTACHMENT B

WELCOME

Dear VEBA Participant:

Welcome to your County of Riverside VEBA Post Employment Health Savings Plan (VEBA HSP). Please carefully review this brochure regarding your VEBA HSP account.

When you separate from service, you may begin withdrawing benefits. The VEBA HSP third-party administrator (TPA) is REHN & ASSOCIATES. You will receive quarterly statements detailing your account activity. If you have questions, you may contact the TPA at the toll-free number on the front of this brochure. The TPA maintains plan records and accounts.

In the event of a discrepancy between this Plan Summary and the actual Plan and Trust documents, the Plan and Trust documents control.

This Plan Summary supersedes any previously published Plan informational materials.

EMPLOYEE BENEFITS

County of Riverside Human Resources

VEBA Post Employment Health Savings Plan

Plan Summary

January 2012

County of Riverside VEBA HSP
Third-party Administrator
REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
Fax: (509) 535-7883
riversideco@rehnonline.com

Plan Consultant
VEBA Service Group, LLC
906 West 2nd Avenue, Suite 400
Spokane, WA 99201-4502
1-800-888-VEBA (8322)
Fax: (509) 838-5613

Trustee
Washington Trust Bank
Spokane, WA

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PART I
Questions & Answers

What is the County of Riverside VEBA Post Employment Health Savings Plan (VEBA HSP)?
The VEBA HSP is a post-employment health reimbursement arrangement (HRA) account. The funds are held in a non-profit, tax-exempt voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) § 501(c)(9). You can use these tax-free funds to reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse, and your qualified children and dependents.

What is an HRA?
An HRA is a type of health plan that reimburses qualified out-of-pocket healthcare costs and insurance premiums. All contributions, investment earnings, and withdrawals (claims) are tax-free.

What is a VEBA?
VEBA stands for voluntary employees' beneficiary association and is a tax-exempt trust authorized by Internal Revenue Code Section 501(c)(9). The tax objectives of this plan are to enable your employer to make tax-free contributions into a trust account on your behalf, your account to be credited with tax-free investment earnings, and to enable you to obtain tax-free reimbursements for your eligible out-of-pocket health care costs and premiums for you, your spouse, and your qualified dependents. VEBA contributions are currently not reportable on your W-2 Form. However, the Patient Protection and Affordable Care Act of 2010 (PPACA) will require the value of health benefits to be reported on Form W-2 for the 2012 tax year. Though the value of health benefits is to be included on Form W-2 for tax year 2012, such amounts will not be taxable. You do not report investment earnings or withdrawals on your personal income tax return. You will not receive a 1099 for earnings or withdrawals.

When and how do I get money out of my VEBA HSP account?
Your VEBA HSP account is now open. After you separate from service, you may submit a completed VEBA HSP Claim Form to the third-party administrator (TPA) for qualified out-of-pocket medical, dental, or vision expenses incurred by you, your spouse, and your qualified children and dependents. You will need to include proper substantiation of your expense such as a detailed receipt or an EOB (Explanation of Benefits) from your insurance provider. Withdrawals from your account can be made for eligible out-of-pocket healthcare expenses and premiums which were incurred after you separate from service.

Claims payment is efficient and hassle free and you may choose direct deposit. Claims are processed weekly, and you may file claims for any amount. Benefits will be paid until your account is used up.

Note: If you separate from service and subsequently return to employment with the County, you may continue to file claims for qualified expenses incurred on or after the date you originally separated from service with the County.

What expenses are eligible for reimbursement?
Eligible expenses include qualified medical, dental, and vision expenses not covered by your insurance plans, or medical, dental, vision, Medicare Part B and Part D, Medicare supplement, and tax-qualified long-term care insurance premiums. Purchases made prior to January 1, 2011 of certain over-the-counter drugs, if properly substantiated, qualify for reimbursement. After January 1, 2011, the law permits expenses for over-the-counter drugs (other than insulin) to be reimbursed only if documentation is provided that the drug was prescribed. Eligible expenses are defined in Internal Revenue Code § 213(d).

Insurance premiums paid by an employer or deducted pre-tax through a Section 125 cafeteria plan, are not eligible for reimbursement.

Whose expenses are eligible for reimbursement?
Your VEBA HSP account covers you, your spouse, and any qualified children and dependents. Qualified dependents are defined in Internal Revenue Code Section 105(b). Additional information is available from the TPA.

Can my VEBA HSP automatically reimburse me for my insurance premiums?
Yes. You may arrange to have monthly insurance premiums reimbursed to you by using the VEBA HSP Systematic Premium Reimbursement Form upon termination from the County. If your spouse or qualified children and dependents are covered by different medical plans, their insurance premiums can also be reimbursed from this account. Simply submit a completed VEBA HSP Systematic Premium Reimbursement Form included in your welcome packet and the TPA will automatically reimburse you for the cost of your premium(s).

You will need to notify the TPA each year by phone, fax, mail, or e-mail if your premium amount changes so that your reimbursement may be changed accordingly.

If CalPERS deducts my medical insurance premiums from my pension, can I request a reimbursement for the payment?

Yes. If CalPERS is deducting your medical insurance premium from your pension check, you may file a VEBA HSP Systematic Premium Reimbursement Form with the TPA and request a reimbursement of your premium amount. You only need to file this form one time and you will receive a monthly reimbursement deposited directly to your checking or savings account.

You will need to notify the TPA each year by phone, fax, mail, or e-mail if your premium amount changes so that your reimbursement may be changed accordingly.

Can I take a loan from my VEBA HSP?

No. Loans are not permissible from the Plan. Per IRS rules, withdrawals (claims) may be for qualified medical, dental, and vision expenses and insurance premiums only.

What happens if I get divorced?

In the event that you become divorced or a legally separated, your account cannot be split as part of a property settlement agreement. Contact the TPA for more information on how a divorce or legal separation affects your account.

What is the death benefit?

If the participant dies with a positive participant account balance, his/her surviving spouse, if any, may file claims for eligible expenses incurred by the participant, the surviving spouse, and any other qualified children and dependents. If a participant dies without a surviving spouse and with qualified children and dependent(s), the guardian(s) of the qualified children and dependent(s) may file claims for eligible expenses on behalf of the qualified children and dependent(s). Upon the death of the last to die of the participant, surviving spouse, or qualified children and dependent(s), the executor or administrator of the estate may file claims for any eligible expenses after which any remaining account balance will be forfeited to the Plan.

How are my funds invested?

The Trust offers you five funds options. You may choose to have all or a portion of your VEBA HSP account in any combination of the following funds:

Fund Name / Fund objective
JPMorgan Investor Growth Fund / Long-term growth
JPMorgan Investor Growth & Income Fund / Long-term growth and current income
JPMorgan Investor Balanced Fund / Total return and capital preservation
JPMorgan Investor Conservative Growth Fund / Income with modest growth
Nationwide Fixed Account/ Stable principal and current income

Investment allocation changes are allowed up to once each calendar month. However, exchanges and/or transfers from the Fixed Account may not exceed four (4) exchanges in a calendar year (January 1 – December 31).

Please carefully study Part IV Investment Fund Information in this brochure and call the VEBA HSP TPA and ask for the Investment Fund Overview. You may also obtain additional information from a VALIC representative or the VEBA HSP TPA. Phone numbers are listed on page four of this Plan Summary.

Will I receive a statement of my account?

You will receive quarterly statements detailing all activity in your account. You may also call and request additional statements at any time from the TPA.

Will my account grow?

The net investment earnings or losses (after expenses are deducted) are credited tax-free to your account on a monthly basis.

How are expenses paid?

Each participant will be charged a monthly fee of $3.00 per month plus an asset-based fee which is converted to a flat dollar amount which will be deducted from each account by the TPA. This fee will help pay for plan expenses such as the TPA fee, postage, printing, trustee/custodial fees, etc. There will also be fees deducted from your accounts as a percent of assets. These will include the investment management fee which varies depending upon which funds you choose.

What is a health savings account (HSA) and can a VEBA HSP participant contribute to an HSA?

HSAs are a type of tax favored medical reimbursement account (your VEBA HSP account is not an HSA). If you want to make contributions to an HSA, you must meet the contribution eligibility requirements. HSA eligibility requirements are contained in the U.S.

Treasury Department's HSA Basics brochure at www.ustreas.gov.

Current IRS rules require that you limit your VEBA HSP coverage to permit the reimbursement of only certain types of expenses and insurance premiums as one of the eligibility requirements if you want to make contributions to an HSA. To limit withdrawals from your VEBA HSP account, simply submit a completed and signed Election of Limited VEBA HSP Plan Coverage Form. If you have any questions, please contact the TPA.

What about amendments or termination of the Plan?
The County reserves the right to amend or discontinue offering the Plan. In the event of Plan termination, plan assets will be treated in accordance with the terms of the Plan Document. Plan amendment may not cause forfeiture or reduction of benefits.

Where do I get more information?
Contact the County of Riverside Human Resources Department or the VEBA HSP TPA.

County of Riverside Human Resources Department
P.O. Box 1569
Riverside, CA 92502
Benefits Information: (951) 955-4981
(select the retirement option)
Fax: (951) 955-8538

VEBA HSP Third-party Administrator (TPA)
REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
Phone: 1-800-VEBA101 (832-2101)
Fax: (509) 535-7883
E-mail: riversideco@rehnonline.com

VEBA Plan Consultant
VEBA Service Group, LLC
906 West 2nd Avenue, Suite 400
Spokane, WA 99201-4502

Investments
JPMorgan Investor Funds
www.jpmorganfunds.com

Local Plan Service
VALIC
333 S. Anita Dr., Suite 875
Orange, CA 92868
1-800-892-5558

VALIC is on site at the County Administrative Center 4080 Lemon St, 1st Floor on Thursdays from 10:30 a.m. to 3:00 p.m.

If you already use a VALIC Financial Representative for your 457 Deferred Compensation and/or 401(a) Money Purchase Plan with the County, contact your Representative to obtain more information or to set up an appointment to discuss the advantages of the VEBA Post Employment Program. If you do not use a VALIC Financial Representative, you can contact the local VALIC office at 1-800-892-5558 to inquire who services your area.

PART II
Other Plan Information

The name of the Plan is the County of Riverside, California Voluntary Employees' Beneficiary Association Post Employment Health Savings Plan.

The assets of the Plan are held in a trust. Washington Trust Bank has been named trustee.

Washington Trust Bank
Attn: Private Banking
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

This Trust is a Voluntary Employees' Beneficiary Association under Internal Revenue Code 501(c)(9).

The Plan administration is conducted by a third party, REHN & ASSOCIATES, P.O. Box 5433, Spokane, WA 99205-0433, 1-800-VEBA101 (832-2101) or (509) 534-0600.

The Plan consultant is VEBA Service Group, LLC, 906 West 2nd Avenue, Suite 400, Spokane, WA 99201, 1-800-888-8322 or (509) 838-5571, Attn: Mark R. Wilkerson, CFP®.

The Trust's investment funds are offered through JPMorgan and Nationwide.

Local plan service and plan education is offered by VALIC, 1-800-892-5558.

The Plan's agent for service of legal process is the County of Riverside Clerk of the Board.

This Plan is provided under collective bargaining agreements or employer policy.

All accounts are 100% vested and the Plan does not discriminate regarding eligibility to participate.

In the event the TPA is unable to locate you, or a dependent of yours, or your personal representative, and your account is unclaimed for a period of at least three years since your whereabouts was last known to the TPA, your account will be forfeited to the Plan, as authorized by California's Unclaimed Property Law, to pay operating expenses of the Plan and your account will terminate.

The Plan year is the calendar year.

Requests for benefits under the Plan must be made in writing to the TPA in accordance with the claims procedure described in this Plan Summary. Requests for benefits which are denied may be appealed in writing to the VEBA HSP third-party administrator.

PART III
Procedure Disputed Claims

If your claim is denied in whole or in part, the TPA shall notify you of the denial. Such notice will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the TPA. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim to the TPA.
After the TPA receives an appeal of a denied claim from you or your authorized representative, the TPA shall deliver the complete file to the Administrator, who shall consider your appeal within 30 days from the time that your appeal was received by the TPA.

In special circumstances, the Administrator may exercise a 15-day extension to review the decision prior to the expiration of the initial 30-day period. The Administrator's decision shall be furnished to you and will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

The Administrator may determine that a hearing is required to properly consider a claim that has been appealed. In that event, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is appealed. After exhausting the above claims procedures in full, if your request for benefits is denied in whole or in part, you or your authorized representative may request an external review of your denied claim. Any such request for review must be delivered to the TPA no later than four months from the date you received written notification of the Administrator's final denial of your request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the TPA will complete a preliminary review to confirm that you are covered under the Plan, you provided all the information and forms necessary to process the external review, and have exhausted the internal appeals process.

Once the review above is complete, the TPA will notify you in writing of the outcome of its review. If you are not eligible for external review, the notice will inform

you of this and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review was incomplete, the notice will describe materials needed to complete the request and you will have the later of 48 hours or the four month filing period to provide the materials needed to complete your filing.

Upon satisfaction of the above requirements, the TPA will assign an independent review organization (IRO) using a method of assignment that assures the independence and impartiality of the assignment process. You may submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by you to the TPA within one (1) business day of receipt. The decision by the IRO is binding on the Plan, as well as on you, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the TPA and to you of its decision to uphold or reverse the benefit denial within no more than forty-five (45) days. An expedited external review in certain circumstances is available and the IRO must provide notice as soon as possible but no later than 72 hours after receipt of the request.

Claims proceedings set forth in this Plan Summary and in more detail in the Plan Document must be strictly adhered to by each claimant and no judicial or arbitration proceedings with respect to any claim for Plan benefits shall be commenced by any such claimant until the appeal has been exhausted in full.

PART IV
Investment Fund Information

INVESTMENT RISK
Accounts invested in stocks or bonds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals (claims) from these funds may be worth more or less than your original deposit.

The Nationwide Fixed Account seeks current income and stability of principal.

Periodically review your selected investment fund choice(s). Should your investment objectives change, you should reevaluate your fund selection(s) and notify the TPA in writing of any changes.

Remember, any investment which contains stock market investments entails the risk of loss. There have been numerous loss periods in the past in these types of funds and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, the stock or bond investments are suitable primarily as longer term investments and should not be for short term use.

TRANSFERS
You may transfer among the funds up to once per calendar month. Transfers are effective the first business day of each month. However, exchanges and/or transfers from the Fixed Account may not exceed four (4) exchanges in a calendar year (January 1 – December 31).

Participants may use an Account Change Form or login to their VEBA HSP online account at www.rehnonline.com to make fund transfers.

Transfer requests must be received in writing by the TPA by the 25th of each month in order to be effective on the 1st business day of the following month.

WITHDRAWALS
If you have multiple funds, withdrawals made from your account will be withdrawn prorata based on your fund allocation percentage on file with the TPA, unless you request otherwise.

USING MULTIPLE FUNDS
You may have your account allocated to a single fund, two funds, three funds, four funds, or to all five funds.

CONTRIBUTIONS
Contributions are held in a short term investment fund and credited with monthly earnings until the 1st of the month following receipt when they will be allocated per the participant's current allocation instructions on file with the TPA. Participants may not make additional contributions to this plan. Rollovers to and/or from the Plan are not permitted.

INVESTMENT FUNDS
Fund Name / Fund objective
JPMorgan Investor Growth Fund / Long-term growth
JPMorgan Investor Growth & Income Fund / Long-term growth and current income
JPMorgan Investor Balanced Fund / Total return and capital preservation

JPMorgan Investor Conservative Growth Fund / Income with modest growth
Nationwide Fixed Account/ Stable principal and current income

INVESTMENT ADVICE
Participants are encouraged to seek advice regarding these investment funds from their personal financial advisor. The County of Riverside, Trustee, Plan Consultant, or TPA do not give investment advice.

INVESTMENT EXPENSES
Investment expenses are expressed as a percent of assets on an annualized basis and paid by a reduction to investment earnings, or if there are no earnings, charged as a deduction to participant accounts.

ADDITIONAL INFORMATION
You may view additional information regarding the JPMorgan funds (including risk, performance, holdings, fees, management, etc.) at www.jpmorgan.com. Fund prospectuses may be viewed on the website and are also available from VALIC, or copies may be obtained from the County's Human Resources Department. Additional information regarding Nationwide Fixed Account may be obtained by logging into your VEBA HSP online account at www.rehnonline.com or by contacting the TPA.

PART V
COBRA Notice, USERRA Rights, and FMLA Notice

Important information regarding COBRA continuation coverage rights for all participating employees, spouses, and covered children.

Introduction
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides participants and those covered by this Plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered children should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the Plan's TPA, REHN & ASSOCIATES.

General information
A "qualifying event" is an event resulting in the loss of continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as "qualified beneficiaries." Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or participant is required to notify the TPA within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage.

Qualifying events
Participating employee. If you are a participating employee, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you experience a reduction in hours of employment affecting eligibility.

Spouse. If you are the spouse of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours of employment affecting eligibility; (3) you become divorced or legally separated from employee; (4) employee passes away; or (5) employee becomes entitled to Medicare benefits.

Covered Children. Covered children of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the

following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours of employment affecting eligibility; (3) employee and spouse become divorced or legally separated; (4) child reaches age limitation or no longer meets definition of qualifying child; (5) employee passes away; or (6) employee becomes entitled to Medicare benefits.

Qualifying event notification
The TPA will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits.

When the qualifying event is due to an active participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); (2) reduction of hours of employment; or (3) death, the employer must notify the TPA within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the TPA within 60 days of the occurrence of such event.

COBRA continuation period
The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA.
COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); or (2) reduction of hours of employment affecting eligibility.

A maximum of up to 36 months is allowed when the qualifying event is due to the participating employee's (1) legal separation or divorce; (2) death; (3) becoming entitled to Medicare benefits; or (4) when a covered child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension
If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the TPA within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period.

Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, death, or becoming entitled to Medicare benefits or when a covered child reaches age limitation (no longer meets the definition of a qualifying child)the covered spouse and/or covered children may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the TPA within 60 days of the occurrence of the second qualifying event.

Information resources
Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the TPA, or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA RIGHTS

If you are on military leave that is governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your covered qualified dependents may elect to continue contributions to the plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the TPA.

FMLA NOTICE

The County of Riverside VEBA HSP plan qualifies as a group health plan under the Family and Medical Leave

Act (FMLA). If you are receiving monthly or other recurring contributions to your VEBA HSP account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave.

PART VI
Privacy Notice

Introduction

This notice informs you of the ways VEBA HSP may use and disclose medical information about you, and describes our obligations and your rights regarding the use and disclosure of medical information.

This notice also describes how you can access such information. Please review carefully. Questions should be directed to the Plan's TPA, REHN & ASSOCIATES at 1-800-VEBA101 (832-2101) or riversideco@rehnonline.com.

Who will follow this notice

The Plan is structured so that your medical information is administered and maintained solely by the Plan's TPA, and neither the Plan, the Plan Sponsor, nor your Employer will create or receive medical information except for summary health information for limited purposes and enrollment/disenrollment information. The TPA and any other third party that assists in the administration of Plan claims are required by law and by contract with the Plan to follow this notice.

Privacy pledge

Medical information about you and your health is personal, and we are committed to protecting it. A record of your health care claims reimbursed under the Plan is kept for administration purposes only. This notice applies to all medical records we maintain.

We are required by law to (1) make sure medical information identifying you is kept private; (2) make sure that information stored or transmitted in electronic form is secure; (3) provide this notice of our legal duties and privacy/security practices concerning medical information about you; and (4) follow the terms of the notice currently in effect.

How we may use and disclose medical information about you

The following categories describe various ways we use and disclose medical information. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share medical information with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.

For health care operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As required by law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To avert a serious threat to health or safety. We may use and disclose medical information about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Special situations: Military and veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' compensation. We may release medical information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Public health risks. We may disclose medical information about you for public health activities such as to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).

Health oversight activities. We may disclose medical information to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections and licensure necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.

Law enforcement. We may release medical information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National security and intelligence activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your rights regarding medical information about you

You have the following rights regarding medical information we maintain about you.

Right to inspect and copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit a written request to the TPA. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.

Right to amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the TPA including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

Right to an accounting of disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations. This includes any unauthorized access, use, disclosure, modification or destruction of electronic medical information or any interference with an information system handling such information. To request an accounting of disclosures, you must submit a written request to the TPA stating a specific time period, which may not be longer than six years, and may not include dates before Plan participation began. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free; you may be charged for additional lists. We will notify you of any charge and you may choose to withdraw or modify your request before any costs are incurred.

Right to request restrictions. You have the right to request a restriction or limitation on the medical

information we use or disclose about you for treatment, payment, health care operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. To request restrictions, you must submit a written request to the TPA detailing (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e., your spouse).

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the TPA specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.

Right to a paper copy of this notice. You have the right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. To obtain a paper copy of this notice, contact the TPA.

Changes to this notice

We reserve the right to change this notice and make the revised notice effective for medical information we already have about you as well as any information we receive in the future.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the TPA. You will not be penalized for filing a complaint.

Other uses of medical information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

PART VII
Medicare Part D Notice of Noncreditable Coverage

To participants, spouses, children and dependents eligible or becoming eligible for Medicare. Important notice regarding your prescription drug coverage under this Plan and Medicare Part D.

Introduction

Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006.

You may have heard about Medicare's prescription drug coverage and wondered how it will affect you. Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage.

Prescription drug coverage provided by this Plan is limited to your available account balance and is considered "non-creditable." In other words, coverage provided by this Plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll.

Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you

have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, children, or dependents are currently Medicare eligible, you need to make a decision.

The terms of this Plan will not change if you choose to enroll in a Medicare prescription drug plan. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources

More detailed information about Medicare plans that offer prescription drug coverage is contained in the *Medicare & You* handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for telephone numbers); or (3) calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at anytime from the TPA.

PART VIII
Coordination of Benefits with Medicare

Coordination of Benefits with Medicare.

If you are entitled to Medicare and are claims eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare. To comply with federal law you should file your claims in accordance with these primary and secondary payer rules.

If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active VEBA HSP account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your VEBA HSP account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA (your VEBA HSP) plans for plan years beginning on or after October 1, 2010, requires the TPA for your VEBA HSP account to report specific information about Medicare beneficiaries who have other group coverage (such as your VEBA HSP coverage). To comply with this federal law, the policies and procedures of the TPA will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims in your VEBA HSP account. In addition, in submitting claims for reimbursement for coverage under your VEBA HSP account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact the TPA or you can call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.