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

222

FROM: Human Resources Department

SUBMITTAL DATE:
January 23, 2014

SUBJECT: Restated Plan Document for the Voluntary Employees' Beneficiary Association (VEBA) Post Employment Health Savings Plan (HSP) [District- All] [Total Cost - $0] [SOURCE OF FUNDS - N/A].

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the attached restated plan document for the Voluntary Employee Beneficiary Association (VEBA) Post Employment Program, effective January 1, 2014.
2. Authorize the Chairperson to sign four (4) copies of the attached plan documents; and
3. Retain one (1) copy of the signed plan document and return three (3) copies of the documents to Human Resources for distribution.

BACKGROUND:

Summary

The County of Riverside VEBA Health Savings Plan (VEBA HSP) was approved by the Board on November 26, 2002. VEBA provides employee benefits in the form of a health reimbursement arrangement; allowing retirees, their spouses, and qualified dependents to receive tax free reimbursement for out-of-pocket health care expenses.

Michael T. Stock
Asst. County Executive Officer /
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 0	$ 0	$ 0	$	Consent ☐ Policy ☒
NET COUNTY COST	$ 0	$ 0	$ 0	$	

SOURCE OF FUNDS:

Budget Adjustment: No

For Fiscal Year:

C.E.O. RECOMMENDATION: APPROVE

BY: Samuel Wong 1/27/14

County Executive Office Signature Samuel Wong

MINUTES OF THE BOARD OF SUPERVISORS

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 1/23/14

Departmental Concurrence

☐ A-30 ☐ 4/5 Vote ☐ Positions Added ☐ Change Order

Prev. Agn. Ref.: 3/20/12, 3.9; 01/10/12, 3.37 | **District: All** | **Agenda Number:** 3-8

BACKGROUND:
Summary (continued)

Due to recent IRS guidance, updates are required to the VEBA HSP which takes effect January 1, 2014. Additional changes incorporate Health Insurance Portability and Accountability Act (HIPAA) provisions from the Omnibus Rule of 2013, and incorporate general housekeeping changes to keep the documents consistent with plan operations and best practices.

The IRS issued new guidance on September 13, 2013, in the form of Notice 2013-54 (Attachment C), which provides that if an HRA account is a participant's only form of group medical coverage, it could under certain limited circumstances cause them to be ineligible for a premium tax credit (subsidy) if they elect to purchase medical coverage through a marketplace exchange. The Notice required that an HRA plan permit a participant to permanently opt out of and waive future reimbursements from the HRA at least annually, and upon termination of employment, which will allow the participant to become eligible for a subsidy.

As an alternative to the forfeiture required under the Notice as permitted by law, participants who want to purchase medical coverage through a marketplace exchange may do so and receive a premium tax credit (subsidy) if the participant elects to convert their HRA coverage to "Pre-Medicare Limited Scope" dental and vision until the participant becomes eligible for Medicare due to age or permanent disability. For participants who make this permanent election, the coverage may convert to full 213(d) coverage at age 65, or earlier if the participant dies or becomes eligible for Medicare due to permanent disability.

If a participant would otherwise be eligible for the subsidy if they did not have an HRA account, the participant may choose to: (1) spend down the VEBA HSP account, (2) forfeit the account and the right to all future reimbursements to become eligible for the subsidy, or (3) elect to limit their benefits until Medicare eligibility to become eligible for the subsidy (i.e. Pre-Medicare Limited Scope coverage)

Applicable law required that the Pre-Medicare Limited Scope coverage be represented by a separate plan document. The administrative requirement will not affect participants. However, there will now be two versions of the Plan: "Full 213(d)" coverage and "Pre-Medicare Limited Scope" coverage.

The general housekeeping changes are considered "best practice" to strengthen the current terms of the Plan and clarify aspects of plan operation. This includes the addition of certain definitions, clarification around claims-eligibility and payment of benefits, and the functions, duties and rights of the Administrator. These changes will not impact or change the current plan administration or operation. The revisions are to help strengthen the descriptions of current plan processes and clarify any ambiguous language to better define operations. All of these revisions are recommended by the Trust attorney and Plan consultant.

Impact on Residents and Businesses
There is no impact on residents or businesses.

SUPPLEMENTAL:
Additional Fiscal Information
This Form 11 is an update to the Plan Document only. Therefore, there is no fiscal impact from this action alone.

ATTACHMENTS:

Attachment A - County of Riverside California Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan (Full 213(d) Medical Benefits Coverage).

Attachment B - County of Riverside California Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan (Pre-Medicare Limited-Scope Coverage).

Attachment C - IRS Notice 2013-54.

Attachment A
(Redline)

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

~~(FULL 213(d) MEDICAL BENEFITS COVERAGE)~~

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~~General Provisions

1.1 Name. The name of this Plan shall be the County of Riverside, California 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 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or otherwise separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

~~1.4~~1.4 Forfeiture of Account Balance and Future Reimbursements for Premium Tax Credit Eligibility. To the extent any Claims-Eligible Participant retains a positive account balance in his or her Participant Account during any month, the Patient Protection and Affordable Care Act (PPACA) provides that such Participant Account will generally constitute minimum essential coverage, as defined under IRC § 5000A, and will therefore preclude the Participant from claiming or becoming entitled to an IRC § 36B premium tax credit during that month to purchase qualified group health coverage from a marketplace exchange established in accordance with PPACA.

1.4.1 Forfeiture Election. In order to become potentially eligible for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Plan may, at any time, elect to permanently waive and forfeit such Participant Account balance as of the date of such election and any future reimbursements after the date of such election. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.4.1 shall be irrevocable and will result in a forfeiture of such Participant Account balance as of the date of such election and all future reimbursements from such Participant Account after the date of such election by the Participant.

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1.4.2 Application of Forfeitures. Any positive account balance that is waived and forfeited pursuant to this Section 1.4 shall be applied as provided in Section 5.1.4.

1.5 Election of Pre-Medicare Limited-Scope Coverage. In lieu of the election permitted under Section 1.4, in order to become potentially eligible for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Plan may, at any time, elect Pre-Medicare Limited-Scope Coverage under this Plan. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.5 shall be irrevocable as of the date of such election with respect to reimbursement of expenses incurred after the date of such election by the Participant. This Pre-Medicare Limited Scope Coverage election is distinguished from the Limited Plan Coverage option available and described further under Section 5.1.

1.6 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Plan and second to the Trust.

~~1.3~~1.7 Definitions.

~~1.3.1~~ "Administrator" means the County of Riverside or its designee, including any Third-party Administrator acting at the direction of the County.

"Benefits" refers to reimbursements for or payments of Medical Benefits as described in Section 5.1.

"Claims-Eligible" with respect to a Participant means that such Participant has become eligible for reimbursement of Medical Benefits under Article V upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements or other Employer action.

~~1.3.2~~ "Dependent" means the Participant's spouse, dependent, or child (who as of the end of the taxable year ~~has not attained~~is age 2~~6 or younger7~~) 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, 201~~2~~4.

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

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~~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.

"Limited Plan Coverage" is coverage that may be limited at the option of a Claims-Eligible Participant who desires to limit his or her Medical Benefits to coordinate with other benefits plans, as provided under Section 5.1.

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~~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.

"PPACA" means the Patient Protection and Affordable Care Act and all rules, regulations, and regulatory guidance applicable to the Plan promulgated thereunder, as the same shall be amended from time to time.

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"Pre-Medicare Limited-Scope Coverage" means the coverage under this Plan, governed by a separate plan document, that (a) limits reimbursements, until a Participant dies or becomes eligible for Medicare due to age or permanent disability, to only Medical Benefits that would not be considered minimum essential coverage under IRC §5000A(f)(3) and (b) allows reimbursement of any Medical Benefits after the earlier of the date a Participant (i) becomes eligible for Medicare due to age or permanent disability or (ii) dies.

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"Re-employed" means, with respect to a Participant who has become Claims-Eligible upon retirement from employment or other separation from service from the Employer, that such Participant has become re-employed with such Employer under any circumstances.

~~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~~this Article II, and subject to the eligibility provisions of Employer policies, ~~and~~ applicable collective bargaining agreements, and state and local law, 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~~Nondiscrimination. 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.

If, after Participant becomes Claims-Eligible (upon separation from service from the Employer), such Participant becomes Re-employed by the Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Medical Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Medical Benefits incurred thereafter.

~~2.3~~

Article III.
Funding of Benefits

3.1 ~~Deposits~~Contributions. The Employer shall ~~deposit~~ contribute to this Plan on behalf of its ~~eligible~~ Employees on terms pursuant to collective bargaining agreements or

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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~~ Participant A~~a~~ccount. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

4.2 Receipt of ~~Deposits~~Contributions. ~~Deposits~~ Contributions for any Plan Year will be credited as received by the ~~Trustee~~ Third-party Administrator and ~~are to~~will be allocated as directed by the ~~Third-party~~ Administrator consistent with Participant investment elections.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 Allocate and credit any Employer ~~deposit~~ contribution 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 Participant Account or which are otherwise allocable to the Participant 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~~ expenses 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~~ care expenses not ~~provided~~ covered 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~~Claims-Eligible or during any period of Re-employment.

A "Limited Plan Coverage" option may be available to Claims-Eligible Participants who desire to limit their Medical Benefits to coordinate with the Participant's other

benefit plans. Such Limited Plan Coverage shall be subject to the limitations and provisions of applicable law and in accordance with rules, regulations and limitations established by the Administrator from time to time. Limited Plan Coverage constitutes minimum essential coverage, as defined under IRC § 5000A, and will not be effective to enable a participant to become potentially eligible for an IRC § 36B premium tax credit. a Participant must make a forfeiture election under Section 1.4 or elect Pre-Medicare Limited-Scope coverage under Section 1.5.

~~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.~~

Claims-Eligible 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 of Participant or Dependent(s). ~~Medical~~ Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s) on or after the Participant becomes Claims-Eligible (but not during any period of Re-employment).

5.1.2 Claims for Benefits. Participants may file claims for ~~Medical~~ Benefits incurred on or after the date the~~y become Claims-Eligible 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)~~. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer. Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement. ~~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, and limitations 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 B~~b~~enefits for any Participant will terminate as of the date when the Participant permanently loses his or her status as a Participant pursuant to Section 2.3~~'s Account has no funds remaining~~.

Article VI.
~~General~~ Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for ~~Medical~~ Benefits under the Plan, or to any one or more Dependents for ~~Medical~~ Benefits under the Plan in the event of the Participant's death ~~under the Plan~~ shall be limited (in the aggregate) to the balance in such Participant's Participant Account. Neither the ~~County of Riverside, California~~Employer, 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 investment options into which the funds in such Participant Account will be allocated. Participant Account 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~~ such Account shall be invested in a default investment. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

6.3 Mechanics of Payment. The Participant, or other person authorized pursuant to a court order or other legal authorization, ~~(~~or in the event of the Participant's death, the deceased Participant's surviving~~a spouse or~~ Dependents or ~~'s~~their legal guardian, in accordance with the rules, policies, and procedures of the Trust), ~~or if no Dependent(s) remain eligible to file claims, the beneficiary determined under Section 5.1.4~~ may submit a request for ~~eligible b~~Benefits to the Third-party Administrator for the Trust~~ee~~:

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, including qualified long-term care 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 to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses; or

~~6.3.3~~6.3.4 To reimburse Medicare and Medicare supplement premiums.

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.

~~6.4.3.4~~6.4.3.5 The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for benefits is not ~~provided~~ received by the claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, ~~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~~ Third-party Administrator 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 first day of the fifth month following 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~~the Department of Health and Human Services Health Insurance Assistance Team (HIAT). 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 VI~~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.

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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, and the Omnibus Rule of 2013 with respect to protecting the privacy and security of P~~p~~rotected H~~h~~ealth ~~i~~Information (PHI).

6.5.1 Plan Uses of Protected Health Information. The Plan shall adhere to procedures regarding the permitted and required uses by, and disclosures to, the Plan of PHI for plan administrative and other permitted purposes. The Plan shall:

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6.5.1.1 not use or disclose PHI other than as permitted by the Plan documents or as required by law;

6.5.1.2 ensure that any agents, subcontractors or business associates to whom the plan provides PHI shall agree to the same restrictions that apply to the Plan;

6.5.1.3 not use or disclose PHI for purposes other than the minimum necessary to administer the Plan;

6.5.1.4 report to the privacy official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.5.1.5 make PHI available to Plan participants, consider their amendments, and, upon request, provide them with an accounting of PHI disclosures in accordance with the HIPAA privacy rules;

6.5.1.6 make internal records relating to the use and disclosure of PHI available to the Department of Health and Human Services upon request; and

6.5.1.7 the Plan shall destroy PHI in accordance with its Document Retention and Destruction Policy when the Plan is no longer required to maintain PHI.

6.6 Employer Uses of Protected Health Information.

6.6.1 HIPAA Plan Amendment. Members of the workforce of the Employer may have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. This provisions of section ~~is also referred to as a~~6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI and Electronic PHI.

The following HIPAA definitions of PHI and Electronic PHI apply to this HIPAA Plan Amendment:

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

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

The Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA. The Employer's privacy official shall be the individual named in the Employer's internal privacy policy.

6.6.2 Provision of Protected Health Information to the Employer. Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the

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Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

Enrollment and disenrollment information shall include, without limitation, name, account number or social security number, contribution history, account balance information, age, employment status (active, retired, separated), account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant.

The Plan and the Employer acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.6.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

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6.6.3.1 *"Summary Health Information"* means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Paragraph IV and obtaining written certification pursuant to Paragraph VI, the Plan may disclose PHI and Electronic PHI to the Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

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6.6.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, and appeals auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

6.6.4.2 Enrollment and disenrollment functions performed by the Employer are performed on behalf of Employees, Plan Participants and Dependents, and are not Plan administration functions.

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

6.6.5 Conditions of Disclosure for Plan Administration Purposes. The Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan, the Employer shall:

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6.6.5.1 not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

6.6.5.2 ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

6.6.5.3 not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

6.6.5.4 report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

6.6.5.5 make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

6.6.5.6 make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

6.6.5.7 make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

6.6.5.8 make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

6.6.5.10 ensure that adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR §504(f)(2)(iii), is established.

6.6.~~5~~.6 Additional Requirements. The Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan or in connection with a Plan Administration Purpose, it will:

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a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. ensure that the adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

d. report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and as soon as feasible, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.6.7 Adequate Separation Between Plan and Employer and Between Employees who perform Plan administration functions and Employees Who Do Not Have Plan administration functions. The Employer receiving any PHI pursuant to this

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HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) from the Plan shall allow access to the PHI to only those employees or classes of employees identified on the Employer's HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employers' employee discipline and termination procedures.

6.6.7.1 The Employer shall ensure that the provisions of this HIPAA Plan Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6.6.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to the Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Paragraph IV and all other conditions and requirements of this HIPAA Plan Amendment.

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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 service providers or designees. ~~The~~ Any 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 at the direction of the Administrator, 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 facilitate the investment elections made by Participants in a manner consistent with the objectives of the Plan and authorized by the Trust.

~~7.1.6~~

~~7.1.7~~7.1.8 To inform the Trustee of the Participants' elections with respect to the investment of Participant Accounts.

~~7.1.8~~7.1.9 To make, publish and interpret such rules for the regulation of this Plan that are not inconsistent with the terms hereof.

~~7.1.9~~7.1.10 ~~If a Third-party Administrator has been named, it shall~~To assume and perform each and every duty and responsibility of the Administrator specified in the Plan documents or otherwise in accordance with applicable law to the extent so delegated ~~to it by the Employer and Trustee~~in writing by the Administrator.

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~~on behalf of 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~~ provide 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 instructions on how to acquire plan forms. The Third-party Administrator shall also ~~mail~~ provide a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial ~~deposit~~contribution, 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~~ provide a written statement quarterly, or at any other time upon request, which shall include the following information: Participant's name and address; ~~deposits~~ contributions 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.

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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, and other service providers 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, and Governmental Fees, Taxes and Assessments. 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. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant 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~~in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employer that this Plan and the payment of Benefits hereunder 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~~ funds under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

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, and provided, however, that such amendment must comply with Article II of the Trust Agreement.

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 by delivering written notice of termination to Participants. 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, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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~~Conflicting Provisions. 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~~Trust, and 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; Severability. 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 which is Claims-Eligible shall have been unclaimed for a continuous 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 B~~b~~enefits 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 or Employer~~, 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~~

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

COUNTY OF RIVERSIDE:

By: _____

~~Barbara A. Olivier~~Michael T. Stock
Asst. CEO / Human Resources Director

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

By: _____
Chairman, Board of Supervisors

Approved to form:

Date: _____

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: _____

Title: V. P.

Address: PO Box 2127

Spokane, WA 99210-2127

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

(FULL 213(d) MEDICAL BENEFITS COVERAGE)

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

Article I.
General Provisions

1.1 Name. The name of this Plan shall be the County of Riverside, California 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, and the individual Enrollment Form, shall constitute the Plan documents.

1.3 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or otherwise separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

1.4 Forfeiture of Account Balance and Future Reimbursements for Premium Tax Credit Eligibility. To the extent any Claims-Eligible Participant retains a positive account balance in his or her Participant Account during any month, the Patient Protection and Affordable Care Act (PPACA) provides that such Participant Account will generally constitute minimum essential coverage, as defined under IRC § 5000A, and will therefore preclude the Participant from claiming or becoming entitled to an IRC § 36B premium tax credit during that month to purchase qualified group health coverage from a marketplace exchange established in accordance with PPACA.

1.4.1 Forfeiture Election. In order to become potentially eligible for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Plan may, at any time, elect to permanently waive and forfeit such Participant Account balance as of the date of such election and any future reimbursements after the date of such election. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.4.1 shall be irrevocable and will result in a forfeiture of such Participant Account balance as of the date of such election and all future reimbursements from such Participant Account after the date of such election by the Participant.

1.4.2 Application of Forfeitures. Any positive account balance that is waived and forfeited pursuant to this Section 1.4 shall be applied as provided in Section 5.1.4.

1.5 Election of Pre-Medicare Limited-Scope Coverage. In lieu of the election permitted under Section 1.4, in order to become potentially eligible for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Plan may, at any time, elect Pre-Medicare Limited-Scope Coverage under this Plan. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.5 shall be irrevocable as of the date of such election with respect to reimbursement of expenses incurred after the date of such election by the Participant. This Pre-Medicare Limited Scope Coverage election is distinguished from the Limited Plan Coverage option available and described further under Section 5.1.

1.6 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Plan and second to the Trust.

1.7 Definitions.

"Administrator" means the County of Riverside or its designee, including any Third-party Administrator acting at the direction of the County.

"Benefits" refers to reimbursements for or payments of Medical Benefits as described in Section 5.1.

"Claims-Eligible" with respect to a Participant means that such Participant has become eligible for reimbursement of Medical Benefits under Article V upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements or other Employer action.

"Dependent" means the Participant's spouse, dependent, or child (who as of the end of the taxable year is age 26 or younger) as determined under IRC § 105(b).

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

"Effective Date" for this Plan document shall be January 1, 2014.

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

"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.

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

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

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

"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.

"Limited Plan Coverage" is coverage that may be limited at the option of a Claims-Eligible Participant who desires to limit his or her Medical Benefits to coordinate with other benefits plans, as provided under Section 5.1.

"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.

"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.

"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.

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

"PPACA" means the Patient Protection and Affordable Care Act and all rules, regulations, and regulatory guidance applicable to the Plan promulgated thereunder, as the same shall be amended from time to time.

"Pre-Medicare Limited-Scope Coverage" means the coverage under this Plan, governed by a separate plan document, that (a) limits reimbursements, until a Participant dies or becomes eligible for Medicare due to age or permanent disability, to only Medical Benefits that would not be considered minimum essential coverage under IRC §5000A(f)(3) and (b) allows reimbursement of any Medical Benefits after the earlier of the date a Participant (i) becomes eligible for Medicare due to age or permanent disability or (ii) dies.

"Re-employed" means, with respect to a Participant who has become Claims-Eligible upon retirement from employment or other separation from service from the Employer, that such Participant has become re-employed with such Employer under any circumstances.

"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.

"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.

"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 this Article II, and subject to the eligibility provisions of Employer policies, applicable collective bargaining agreements, and state and local law, 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 Nondiscrimination. 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.

If, after Participant becomes Claims-Eligible (upon separation from service from the Employer), such Participant becomes Re-employed by the Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Medical Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Medical Benefits incurred thereafter.

Article III.
Funding of Benefits

3.1 Contributions. The Employer shall contribute to this Plan on behalf of its 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 Participant Account. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

4.2 Receipt of Contributions. Contributions for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Administrator consistent with Participant investment elections.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 Allocate and credit any Employer contribution 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 Participant Account or which are otherwise allocable to the Participant 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 expenses 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 care expenses not covered 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 Claims-Eligible or during any period of Re-employment.

A "Limited Plan Coverage" option may be available to Claims-Eligible Participants who desire to limit their Medical Benefits to coordinate with the Participant's other benefit plans. Such Limited Plan Coverage shall be subject to the limitations and provisions of applicable law and in accordance with rules, regulations and limitations established by the Administrator from time to time. Limited Plan Coverage constitutes minimum essential coverage, as defined under IRC § 5000A, and will not be effective to enable a participant to become potentially eligible for an IRC § 36B premium tax credit, a Participant must make a

forfeiture election under Section 1.4 or elect Pre-Medicare Limited-Scope coverage under Section 1.5.

Claims-Eligible 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 of Participant or Dependent(s). Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s) on or after the Participant becomes Claims-Eligible (but not during any period of Re-employment).

5.1.2 Claims for Benefits. Participants may file claims for Benefits incurred on or after the date they become Claims-Eligible, 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. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer. Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

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, regulations, and limitations 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 for any Participant will terminate as of the date when the Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to any one or more Dependents for Benefits under the Plan in the event of the Participant's death shall be limited (in the aggregate) to the balance in such Participant's Participant Account. Neither the Employer, 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 investment options into which the funds in such Participant Account will be allocated. Participant Account 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, such Account shall be invested in a default investment. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

6.3 Mechanics of Payment. The Participant, or other person authorized pursuant to a court order or other legal authorization (or in the event of the Participant's death, the deceased Participant's surviving Dependents or their legal guardian, in accordance with the rules, policies, and procedures of the Trust), may submit a request for Benefits to the Third-party Administrator for the Trust:

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, including qualified long-term care premiums; or

6.3.2 To reimburse Medical Benefits for COBRA premium payments; or

6.3.3 To reimburse out-of-pocket Medical Benefits to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses; or

6.3.4 To reimburse Medicare and Medicare supplement premiums.

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 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.

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for benefits is not received by the claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, 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 Third-party Administrator 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 the first day of the fifth month following 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 the Department of Health and Human Services Health Insurance Assistance Team (HIAT). 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.

6.4.10 The claims procedures set forth in this Article VI 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, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009,

and the Omnibus Rule of 2013 with respect to protecting the privacy and security of Protected Health Information (PHI).

6.5.1 Plan Uses of Protected Health Information. The Plan shall adhere to procedures regarding the permitted and required uses by, and disclosures to, the Plan of PHI for plan administrative and other permitted purposes. The Plan shall:

6.5.1.1 not use or disclose PHI other than as permitted by the Plan documents or as required by law;

6.5.1.2 ensure that any agents, subcontractors or business associates to whom the plan provides PHI shall agree to the same restrictions that apply to the Plan;

6.5.1.3 not use or disclose PHI for purposes other than the minimum necessary to administer the Plan;

6.5.1.4 report to the privacy official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.5.1.5 make PHI available to Plan participants, consider their amendments, and, upon request, provide them with an accounting of PHI disclosures in accordance with the HIPAA privacy rules;

6.5.1.6 make internal records relating to the use and disclosure of PHI available to the Department of Health and Human Services upon request; and

6.5.1.7 the Plan shall destroy PHI in accordance with its Document Retention and Destruction Policy when the Plan is no longer required to maintain PHI.

6.6 Employer Uses of Protected Health Information.

6.6.1 HIPAA Plan Amendment. Members of the workforce of the Employer may have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. This provisions of section 6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI and Electronic PHI.

The following HIPAA definitions of PHI and Electronic PHI apply to this HIPAA Plan Amendment:

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

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

The Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA. The Employer's privacy official shall be the individual named in the Employer's internal privacy policy.

6.6.2 Provision of Protected Health Information to the Employer. Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

Enrollment and disenrollment information shall include, without limitation, name, account number or social security number, contribution history, account balance information, age, employment status (active, retired, separated), account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant.

The Plan and the Employer acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.6.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

6.6.3.1 *"Summary Health Information"* means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Paragraph IV and obtaining written certification pursuant to Paragraph VI, the Plan may disclose PHI and Electronic PHI to the Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.6.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, and appeals auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

6.6.4.2 Enrollment and disenrollment functions performed by the Employer are performed on behalf of Employees, Plan Participants and Dependents, and are not Plan administration functions.

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

6.6.5 Conditions of Disclosure for Plan Administration Purposes. The Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan, the Employer shall:

6.6.5.1 not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

6.6.5.2 ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

6.6.5.3 not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

6.6.5.4 report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

6.6.5.5 make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

6.6.5.6 make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

6.6.5.7 make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

6.6.5.8 make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

6.6.5.10 ensure that adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR §504(f)(2)(iii), is established.

6.6.6 Additional Requirements. The Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan or in connection with a Plan Administration Purpose, it will:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. ensure that the adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the

Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

d. report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and as soon as feasible, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.6.7 Adequate Separation Between Plan and Employer and Between Employees who perform Plan administration functions and Employees Who Do Not Have Plan administration functions. The Employer receiving any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) from the Plan shall allow access to the PHI to only those employees or classes of employees identified on the Employer's HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employers' employee discipline and termination procedures.

6.6.7.1 The Employer shall ensure that the provisions of this HIPAA Plan Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6.6.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to the Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to

the conditions of disclosure set forth in Paragraph IV and all other conditions and requirements of this HIPAA Plan Amendment.

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 service providers or designees. Any Third-party Administrator shall exercise its discretion in a uniform, nondiscriminatory manner and shall have all necessary power and discretion to accomplish those purposes at the direction of the Administrator, 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 facilitate the investment elections made by Participants in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

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

7.1.10 To assume and perform each and every duty and responsibility of the Administrator specified in the Plan documents or otherwise in accordance with applicable law to the extent so delegated in writing by the Administrator.

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 on behalf of 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 provide 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 instructions on how to acquire plan forms. The Third-party Administrator shall also provide a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial contribution, 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 provide a written statement quarterly, or at any other time upon request, which shall include the following information: Participant's name and address; contributions 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, accountants, and other service providers 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, and Governmental Fees, Taxes and Assessments. 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. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Employer from time to time.

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 in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employer that this Plan and the payment of Benefits hereunder 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 funds under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

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, and provided, however, that such amendment must comply with Article II of the Trust Agreement.

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 by delivering written notice of termination to Participants. 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, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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; or

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

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, 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 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 Trust, and then the Enrollment Form. The terms of the Plan document with the higher order of priority shall control with respect to any such conflict.

9.2 Applicable Law; Severability. 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 which is Claims-Eligible shall have been unclaimed for a continuous 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 or Employer by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process.

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

COUNTY OF RIVERSIDE:

By: _____
Michael T. Stock
Asst. CEO / Human Resources Director

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

By: _____
Chairman, Board of Supervisors

Approved to form:

Date: _____

Pamela J. Walls
County Counsel

By: _____ 1/23/14
Deputy County Counsel

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: _____

Title: V. P.

Address: P. O. Box 2127

Spokane, WA 99210-2127

_____

Attachment B
(Redline)

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

(PRE-MEDICARE LIMITED-SCOPE COVERAGE)

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~~General Provisions

1.1 Name. The name of this Plan shall be the County of Riverside, California 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 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or otherwise separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

~~1.4~~1.4 Pre-Medicare Limited-Scope Coverage. For any Participant who has irrevocably elected Pre-Medicare Limited-Scope Coverage under this Plan:

1.4.1 Limited-Scope Coverage prior to Medicare-eligibility. Until the Participant (i) becomes eligible for Medicare due to age or permanent disability or (ii) dies, Medical Benefits for expenses incurred by such Participant or his or her Dependents after the date of such election of Pre-Medicare Limited-Scope Coverage shall be limited to reimbursement of expenses and insurance premiums for any Medical Benefits that would not be considered minimum essential coverage under IRC § 5000A(f)(3).

1.4.2 Full 213(d) Medical Benefits after Medicare-eligibility. After the earlier to occur of (i) the Participant's eligibility for Medicare due to age or permanent disability or (ii) the Participant's death, the Pre-Medicare Limited-Scope Coverage under Section 1.4.1 may be terminated, and Medical Benefits for expenses incurred by such Participant and his or her Dependents after the date of such termination of Pre-Medicare Limited-Scope Coverage shall include reimbursements for any expense that constitutes a Medical Benefit.

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1.5 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Plan and second to the Trust.

~~1.3~~ 1.6 Definitions.

~~1.3.1~~ "Administrator" means the County of Riverside or its designee, including any Third-party Administrator acting at the direction of the County.

"Benefits" refers to reimbursements for or payments of Medical Benefits as described in Section 5.1.

"Claims-Eligible" with respect to a Participant means that such Participant has become eligible for reimbursement of Medical Benefits under Article V upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements or other Employer action.

~~1.3.2~~ "Dependent" means the Participant's spouse, dependent, or child (who as of the end of the taxable year ~~has not attained~~is age 26 or younger~~7~~) 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, 201~~2~~4.

~~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.

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~~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.

"PPACA" means the Patient Protection and Affordable Care Act and all rules, regulations, and regulatory guidance applicable to the Plan promulgated thereunder, as the same shall be amended from time to time.

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"Re-employed" means, with respect to a Participant who has become Claims-Eligible upon retirement from employment or other separation from service from the Employer, that such Participant has become re-employed with such Employer under any circumstances.

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~~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.

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~~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~~this Article II, and subject to the eligibility provisions of Employer policies, ~~and~~ applicable collective bargaining agreements, and state and local law, 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~~Nondiscrimination. 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.

If, after Participant becomes Claims-Eligible (upon separation from service from the Employer), such Participant becomes Re-employed by the Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Medical Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Medical Benefits incurred thereafter.

~~2.3~~

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Article III.
Funding of Benefits

3.1 ~~Deposits~~Contributions. The Employer shall ~~deposit~~ contribute 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~~ Participant Aaccount. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

4.2 Receipt of ~~Deposits~~Contributions. ~~Deposits~~ Contributions for any Plan Year will be credited as received by the ~~Trustee~~ Third-party Administrator and ~~are to~~will be allocated as directed by the ~~Third-party~~ Administrator consistent with Participant investment elections.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 Allocate and credit any Employer ~~deposit~~ contribution 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 Participant Account or which are otherwise allocable to the Participant Account that have not been charged previously.

Article V.
Medical Benefits

5.1 Medical Benefits. Subject to the limitations under Section 1.4, Medical Benefits must be payment or reimbursement for medical care ~~benefits~~ expenses 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~~ care expenses not ~~provided~~ covered 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~~Claims-Eligible or during any period of Re-employment.

~~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.~~

Claims-Eligible 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 of Participant or Dependent(s). ~~Medical~~ Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s) on or after the Participant becomes Claims-Eligible (but not during any period of Re-employment).

5.1.2 Claims for Benefits. Participants may file claims for ~~Medical~~ Benefits incurred on or after the date the~~y become Claims-Eligible~~~~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)~~. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer. Reimbursement for any claim submitted in

accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement. ~~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, and limitations 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 ~~B~~benefits for any Participant will terminate as of the date when the Participant permanently loses his or her status as a Participant pursuant to Section 2.3~~'s Account has no funds remaining~~.

Article VI.
~~General~~ Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for ~~Medical~~ Benefits under the Plan, or to any one or more Dependents for ~~Medical~~ Benefits under the Plan in the event of the Participant's death ~~under the Plan~~ shall be limited (in the aggregate) to the balance in such Participant's Participant Account. Neither the ~~County of Riverside, California~~Employer, 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 investment options into which the funds in such Participant Account will be allocated. Participant Account 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~~ such Account shall be invested in a default investment. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

6.3 Mechanics of Payment. The Participant, or other person authorized pursuant to a court order or other legal authorization, (or in the event of the Participant's death, the deceased Participant's survivinga spouse or Dependents or 's their legal guardian, in accordance with the rules, policies, and procedures of the Trust), or if no Dependent(s) remain eligible to file claims, the beneficiary determined under Section 5.1.4 may submit a request for eligible bBenefits 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, including qualified long-term care 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 to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses; or

6.3.36.3.4 To reimburse Medicare and Medicare supplement premiums.

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.

~~6.4.3.4~~6.4.3.5 The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for benefits is not ~~provided~~ received by the claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator. ~~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.

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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~~ Third-party Administrator 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 first day of the fifth month following 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~~the Department of Health and Human Services Health Insurance Assistance Team (HIAT). 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 VI~~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, and the Omnibus Rule of 2013 with respect to protecting the privacy and security of P~~p~~rotected H~~h~~ealth ~~i~~Information (PHI).

6.5.1 Plan Uses of Protected Health Information. The Plan shall adhere to procedures regarding the permitted and required uses by, and disclosures to, the Plan of PHI for plan administrative and other permitted purposes. The Plan shall:

6.5.1.1 not use or disclose PHI other than as permitted by the Plan documents or as required by law;

6.5.1.2 ensure that any agents, subcontractors or business associates to whom the plan provides PHI shall agree to the same restrictions that apply to the Plan;

6.5.1.3 not use or disclose PHI for purposes other than the minimum necessary to administer the Plan;

6.5.1.4 report to the privacy official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.5.1.5 make PHI available to Plan participants, consider their amendments, and, upon request, provide them with an accounting of PHI disclosures in accordance with the HIPAA privacy rules;

6.5.1.6 make internal records relating to the use and disclosure of PHI available to the Department of Health and Human Services upon request; and

6.5.1.7 the Plan shall destroy PHI in accordance with its Document Retention and Destruction Policy when the Plan is no longer required to maintain PHI.

6.6 Employer Uses of Protected Health Information.

6.6.1 HIPAA Plan Amendment. Members of the workforce of the Employer may have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. This provisions of section ~~is also referred to as a~~6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI and Electronic PHI.

The following HIPAA definitions of PHI and Electronic PHI apply to this HIPAA Plan Amendment:

"Protected Health Information (PHI)" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or

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condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased and also includes Electronic PHI.

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

The Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA. The Employer's privacy official shall be the individual named in the Employer's internal privacy policy.

6.6.2 Provision of Protected Health Information to the Employer. Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

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Enrollment and disenrollment information shall include, without limitation, name, account number or social security number, contribution history, account balance information, age, employment status (active, retired, separated), account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant.

The Plan and the Employer acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.6.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

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6.6.3.1 *"Summary Health Information"* means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and

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subject to the conditions of disclosure described in Paragraph IV and obtaining written certification pursuant to Paragraph VI, the Plan may disclose PHI and Electronic PHI to the Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.6.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing and appeals, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

6.6.4.2 Enrollment and disenrollment functions performed by the Employer are performed on behalf of Employees, Plan Participants and Dependents, and are not Plan administration functions.

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

6.6.5 Conditions of Disclosure for Plan Administration Purposes. The Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan, the Employer shall:

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6.6.5.1 not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

6.6.5.2 ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

6.6.5.3 not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

6.6.5.4 report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

6.6.5.5 make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

6.6.5.6 make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

6.6.5.7 make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

6.6.5.8 make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

6.6.5.10 ensure that adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR §504(f)(2)(iii), is established.

6.6.5.6 Additional Requirements. The Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan or in connection with a Plan Administration Purpose, it will:

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a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. ensure that the adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

d. report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and as soon as feasible, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.6.7 Adequate Separation Between Plan and Employer and Between Employees who perform Plan administration functions and Employees Who Do Not Have Plan administration functions. The Employer receiving any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) from the Plan shall allow access to the PHI to only those employees or classes of employees identified on the Employer's HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employers' employee discipline and termination procedures.

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6.6.7.1 The Employer shall ensure that the provisions of this HIPAA Plan Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6.6.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to the Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Paragraph IV and all other conditions and requirements of this HIPAA Plan Amendment.

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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 service providers or designees. ~~The~~ Any 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 at the direction of the Administrator, 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 facilitate the investment elections made by Participants in a manner consistent with the objectives of the Plan and authorized by the Trust.

~~7.1.6~~

~~7.1.7~~7.1.8 To inform the Trustee of the Participants' elections with respect to the investment of Participant Accounts.

~~7.1.8~~7.1.9 To make, publish and interpret such rules for the regulation of this Plan that are not inconsistent with the terms hereof.

~~7.1.9~~7.1.10 ~~If a Third-party Administrator has been named, it shall~~To assume and perform each and every duty and responsibility of the Administrator specified in the Plan documents or otherwise in accordance with applicable law to the extent so delegated ~~to it by the Employer and Trustee~~in writing by the Administrator.

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~~on behalf of 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~~ provide to each Participant information relative to the Participant's Account and how to request

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payment of benefits. The information will include a summary of the Plan, including claim procedures and instructions on how to acquire plan forms. The Third-party Administrator shall also ~~mail~~ provide a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial ~~deposit~~contribution, 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~~ provide a written statement quarterly, or at any other time upon request, which shall include the following information: Participant's name and address; ~~deposits~~ contributions 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, and other service providers 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, and Governmental Fees, Taxes and Assessments. 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. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant 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~~in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employer that this Plan and the payment of Benefits hereunder 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~~ funds under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

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, and provided, however, that such amendment must comply with Article II of the Trust Agreement.

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 by delivering written notice of termination to Participants. 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, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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~~Conflicting Provisions. 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~~Trust, and 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; Severability. 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 which is Claims-Eligible shall have been unclaimed for a continuous 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 Bbenefits 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 or Employer, 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~~

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

COUNTY OF RIVERSIDE:

By: _____

~~Barbara A. Olivier~~Michael T. Stock
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: V. P.

Address: PO Box 2127

Spokane, WA 99210-2127

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

(PRE-MEDICARE LIMITED-SCOPE COVERAGE)

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

Article I.
General Provisions

1.1 Name. The name of this Plan shall be the County of Riverside, California 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, and the individual Enrollment Form, shall constitute the Plan documents.

1.3 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or otherwise separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

1.4 Pre-Medicare Limited-Scope Coverage. For any Participant who has irrevocably elected Pre-Medicare Limited-Scope Coverage under this Plan:

1.4.1 Limited-Scope Coverage prior to Medicare-eligibility. Until the Participant (i) becomes eligible for Medicare due to age or permanent disability or (ii) dies, Medical Benefits for expenses incurred by such Participant or his or her Dependents after the date of such election of Pre-Medicare Limited-Scope Coverage shall be limited to reimbursement of expenses and insurance premiums for any Medical Benefits that would not be considered minimum essential coverage under IRC § 5000A(f)(3).

1.4.2 Full 213(d) Medical Benefits after Medicare-eligibility. After the earlier to occur of (i) the Participant's eligibility for Medicare due to age or permanent disability or (ii) the Participant's death, the Pre-Medicare Limited-Scope Coverage under Section 1.4.1 may be terminated, and Medical Benefits for expenses incurred by such Participant and his or her Dependents after the date of such termination of Pre-Medicare Limited-Scope Coverage shall include reimbursements for any expense that constitutes a Medical Benefit.

1.5 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Plan and second to the Trust.

1.6 Definitions.

"Administrator" means the County of Riverside or its designee, including any Third-party Administrator acting at the direction of the County.

"Benefits" refers to reimbursements for or payments of Medical Benefits as described in Section 5.1.

"Claims-Eligible" with respect to a Participant means that such Participant has become eligible for reimbursement of Medical Benefits under Article V upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements or other Employer action.

"Dependent" means the Participant's spouse, dependent, or child (who as of the end of the taxable year is age 26 or younger) as determined under IRC § 105(b).

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

"Effective Date" for this Plan document shall be January 1, 2014.

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

"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.

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

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

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

"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.

"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.

"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.

"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.

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

"PPACA" means the Patient Protection and Affordable Care Act and all rules, regulations, and regulatory guidance applicable to the Plan promulgated thereunder, as the same shall be amended from time to time.

"Re-employed" means, with respect to a Participant who has become Claims-Eligible upon retirement from employment or other separation from service from the Employer, that such Participant has become re-employed with such Employer under any circumstances.

"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.

"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.

"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 this Article II, and subject to the eligibility provisions of Employer policies, applicable collective bargaining agreements, and state and local law, 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 Nondiscrimination. 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.

If, after Participant becomes Claims-Eligible (upon separation from service from the Employer), such Participant becomes Re-employed by the Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Medical Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Medical Benefits incurred thereafter.

Article III.
Funding of Benefits

3.1 Contributions. The Employer shall contribute to this Plan on behalf of its 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 Participant Account. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

4.2 Receipt of Contributions. Contributions for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Administrator consistent with Participant investment elections.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 Allocate and credit any Employer contribution 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 Participant Account or which are otherwise allocable to the Participant Account that have not been charged previously.

Article V.
Medical Benefits

5.1 Medical Benefits. Subject to the limitations under Section 1.4, Medical Benefits must be payment or reimbursement for medical care expenses 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 care expenses not covered 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 Claims-Eligible or during any period of Re-employment.

Claims-Eligible 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 of Participant or Dependent(s). Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s) on or after the Participant becomes Claims-Eligible (but not during any period of Re-employment).

5.1.2 Claims for Benefits. Participants may file claims for Benefits incurred on or after the date they become Claims-Eligible, 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. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer. Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

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, regulations, and limitations 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 for any Participant will terminate as of the date when the Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to any one or more Dependents for Benefits under the Plan in the event of the Participant's death shall be limited (in the aggregate) to the balance in such Participant's Participant Account. Neither the Employer, 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 investment options into which the funds in such Participant Account will be allocated. Participant Account 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, such Account shall be invested in a default investment. Separate investments shall not be required to be maintained with respect to separate Participant Accounts.

6.3 Mechanics of Payment. The Participant, or other person authorized pursuant to a court order or other legal authorization (or in the event of the Participant's death, the deceased Participant's surviving Dependents or their legal guardian, in accordance with the rules, policies, and procedures of the Trust), may submit a request for Benefits to the Third-party Administrator for the Trust:

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, including qualified long-term care premiums; or

6.3.2 To reimburse Medical Benefits for COBRA premium payments; or

6.3.3 To reimburse out-of-pocket Medical Benefits to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses; or

6.3.4 To reimburse Medicare and Medicare supplement premiums.

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 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.

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request

for benefits is not received by the claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, 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 Third-party Administrator 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 the first day of the fifth month following 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 the Department of Health and Human Services Health Insurance Assistance Team (HIAT). 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.

6.4.10 The claims procedures set forth in this Article VI 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, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and the Omnibus Rule of 2013 with respect to protecting the privacy and security of Protected Health Information (PHI).

6.5.1 Plan Uses of Protected Health Information. The Plan shall adhere to procedures regarding the permitted and required uses by, and disclosures to, the Plan of PHI for plan administrative and other permitted purposes. The Plan shall:

6.5.1.1 not use or disclose PHI other than as permitted by the Plan documents or as required by law;

6.5.1.2 ensure that any agents, subcontractors or business associates to whom the plan provides PHI shall agree to the same restrictions that apply to the Plan;

6.5.1.3 not use or disclose PHI for purposes other than the minimum necessary to administer the Plan;

6.5.1.4 report to the privacy official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.5.1.5 make PHI available to Plan participants, consider their amendments, and, upon request, provide them with an accounting of PHI disclosures in accordance with the HIPAA privacy rules;

6.5.1.6 make internal records relating to the use and disclosure of PHI available to the Department of Health and Human Services upon request; and

6.5.1.7 the Plan shall destroy PHI in accordance with its Document Retention and Destruction Policy when the Plan is no longer required to maintain PHI.

6.6 Employer Uses of Protected Health Information.

6.6.1 HIPAA Plan Amendment. Members of the workforce of the Employer may have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. This provisions of section 6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI and Electronic PHI.

The following HIPAA definitions of PHI and Electronic PHI apply to this HIPAA Plan Amendment:

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

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

The Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA. The Employer's privacy official shall be the individual named in the Employer's internal privacy policy.

6.6.2 Provision of Protected Health Information to the Employer. Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

Enrollment and disenrollment information shall include, without limitation, name, account number or social security number, contribution history, account balance information, age, employment status (active, retired, separated), account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant.

The Plan and the Employer acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the

Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.6.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

6.6.3.1 *"Summary Health Information"* means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Paragraph IV and obtaining written certification pursuant to Paragraph VI, the Plan may disclose PHI and Electronic PHI to the Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.6.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing and appeals, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

6.6.4.2 Enrollment and disenrollment functions performed by the Employer are performed on behalf of Employees, Plan Participants and Dependents, and are not Plan administration functions.

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

6.6.5 Conditions of Disclosure for Plan Administration Purposes. The Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan, the Employer shall:

6.6.5.1 not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

6.6.5.2 ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

6.6.5.3 not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

6.6.5.4 report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

6.6.5.5 make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

6.6.5.6 make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

6.6.5.7 make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

6.6.5.8 make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

6.6.5.10 ensure that adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR §504(f)(2)(iii), is established.

6.6.6 Additional Requirements. The Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI

below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan or in connection with a Plan Administration Purpose, it will:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. ensure that the adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

d. report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and as soon as feasible, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.6.7 Adequate Separation Between Plan and Employer and Between Employees who perform Plan administration functions and Employees Who Do Not Have Plan administration functions. The Employer receiving any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Paragraph VI below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) from the Plan shall allow access to the PHI to only those employees or classes of employees identified on the Employer's HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to

disciplinary action by the Employer for non-compliance pursuant to the Employers' employee discipline and termination procedures.

6.6.7.1 The Employer shall ensure that the provisions of this HIPAA Plan Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6.6.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to the Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Paragraph IV and all other conditions and requirements of this HIPAA Plan Amendment.

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 service providers or designees. Any Third-party Administrator shall exercise its discretion in a uniform, nondiscriminatory manner and shall have all necessary power and discretion to accomplish those purposes at the direction of the Administrator, 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 facilitate the investment elections made by Participants in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

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

7.1.10 To assume and perform each and every duty and responsibility of the Administrator specified in the Plan documents or otherwise in accordance with applicable law to the extent so delegated in writing by the Administrator.

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 on behalf of 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 provide 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 instructions on how to acquire plan forms. The Third-party Administrator shall also provide a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial contribution, 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 provide a written statement quarterly, or at any other time upon request, which shall include the following information: Participant's name and address; contributions 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, accountants, and other service providers 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, and Governmental Fees, Taxes and Assessments. 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. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Employer from time to time.

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 in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employer that this Plan and the payment of Benefits hereunder 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 funds under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

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, and provided, however, that such amendment must comply with Article II of the Trust Agreement.

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 by delivering written notice of termination to Participants. 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, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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; or

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

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, 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 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 Trust, and then the Enrollment Form. The terms of the Plan document with the higher order of priority shall control with respect to any such conflict.

9.2 Applicable Law; Severability. 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 which is Claims-Eligible shall have been unclaimed for a continuous 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 or Employer by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process.

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

COUNTY OF RIVERSIDE:

By: _____
Michael T. Stock
Asst. CEO / Human Resources Director

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

By: _____
Chairman, Board of Supervisors

Approved to form:

Date: _____

Pamela J. Walls
County Counsel

By: _____ 1/27/14
Deputy County Counsel

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: _____

Title: V.P.

Address: P.O. Box 2127
Spokane, WA 99210-2127

_____

Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements

Notice 2013-54

I. PURPOSE AND OVERVIEW

This notice provides guidance on the application of certain provisions of the Affordable Care Act[1] to the following types of arrangements: (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan; (2) group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, such as a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee (collectively, an employer payment plan); and (3) certain health flexible spending arrangements (health FSAs). This notice also provides guidance on section 125(f)(3) of the Internal Revenue Code (Code) and on employee assistance programs or EAPs.

The Departments of the Treasury (Treasury Department), Health and Human Services (HHS), and Labor (DOL) (collectively, the Departments) are continuing to work together to develop coordinated regulations and other administrative guidance to assist stakeholders with implementation of the Affordable Care Act. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice.

II. BACKGROUND

A. Health Reimbursement Arrangements

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45, 2002-02 CB 93; Revenue Ruling 2002-41, 2002-2 CB 75. This reimbursement is excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs generally are considered to be group health plans within the meaning of Code § 9832(a), § 733(a) of the Employee Retirement Income Security Act of 1974 (ERISA), and § 2791(a) of the Public Health Service Act (PHS Act) and are subject to the rules applicable to group health plans.

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[1] The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

B. Employer Payment Plans

Revenue Ruling 61-146 holds that if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. An employer payment plan, as the term is used in this notice, does not include an employer-sponsored arrangement under which an employee may choose either cash or an after-tax amount to be applied toward health coverage. Individual employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation at 29 C.F.R. §2510.3-1(j) are met.

C. Health Flexible Spending Arrangements (Health FSAs)

In general, a health FSA is a benefit designed to reimburse employees for medical care expenses (as defined in Code § 213(d), other than premiums) incurred by the employee, or the employee's spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.125-5); Code §§ 105(b) and 106(f). Contributions to a health FSA offered through a cafeteria plan satisfying the requirements of Code § 125 (a Code § 125 plan) do not result in gross income to the employee. Code § 125(a). While employees electing coverage under a health FSA typically also elect to enter into a salary reduction agreement, employers may provide additional health FSA benefits in excess of the salary reduction amount. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43955-43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §§1.125-1(r), 1.125-5(b)). For plan years beginning after December 31, 2012, the amount of the salary reduction is limited by Code § 125(i) to $2,500 (indexed annually for plan years beginning after December 31, 2013). See IRS Notice 2012-40, 2012-26 IRB 1046, for more information about the application of the limitation. Additional employer contributions are not limited by Code § 125(i).

The Code, ERISA, and the PHS Act impose various requirements on group health plans, but certain of these requirements do not apply to a group health plan in relation to its provision of excepted benefits. Code § 9831(b), ERISA § 732(b), PHS Act §§ 2722(b) and 2763. Although a health FSA is a group health plan within the meaning of Code § 9832(a), ERISA § 733(a), and PHS Act § 2791(a), a health FSA may be considered to provide only excepted benefits if other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer, but only if the arrangement is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. §146.145(c)(3)(v).

D. Affordable Care Act Guidance

1. Market Reforms — In General

The Affordable Care Act contains certain market reforms that apply to group health plans (the market reforms).[2] In accordance with Code § 9831(a)(2) and ERISA § 732(a), the market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year, and, in accordance with Code § 9831(b), ERISA § 732(b), and PHS Act §§ 2722(b) and 2763, the market reforms also do not apply to a group health plan in relation to its provision of excepted benefits described in Code § 9832(c), ERISA § 733(c) and PHS Act § 2791(c).[3] Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs.

The market reforms specifically addressed in this notice are:[4]

(a) PHS Act § 2711 which provides that a group health plan (or a health insurance issuer offering group health insurance coverage) may not establish any annual limit on the dollar amount of benefits for any individual—this rule does not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing an annual limit, with respect to any individual, on specific covered benefits that are not essential health benefits[5] to the extent that such limits are otherwise permitted under applicable law (the annual dollar limit prohibition); and

(b) PHS Act § 2713 which requires non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services (the preventive services requirements).

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[2] Section 1001 of the ACA added new PHS Act §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

[3] See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010). See also Affordable Care Act Implementation FAQs Part III, Question 1, available at http://www.dol.gov/ebsa/faqs/faq-aca3.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html.

[4] The Departments previously addressed HRAs and the requirements under PHS Act § 2715 (summary of benefits and coverage and uniform glossary). See 77 Fed. Reg. 8668, 8670-8671 (February 14, 2012); see also Affordable Care Act Implementation FAQs Part VIII, Question 6, available at http://www.dol.gov/ebsa/faqs/faq-aca8.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html and see page 1 of the Instruction Guide for Group Coverage, available at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

[5] See ACA § 1302(b) for the definition of "essential health benefits".

2. Prior Guidance on the Application of the Market Reforms to HRAs

The preamble to the interim final regulations implementing the annual dollar limit prohibition states that if an HRA is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual dollar limit prohibition, the fact that benefits under the HRA by itself are limited does not fail to comply with the annual dollar limit prohibition because the combined benefit satisfies the requirements. Further, the preamble states that in the case of a standalone HRA that is limited to retirees, the exemption from the requirements of the Code and ERISA relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is not subject to the annual dollar limit prohibition. 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010).

On January 24, 2013, the Departments issued FAQs that address the application of the annual dollar limit prohibition to certain HRA arrangements (HRA FAQs).[6] In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition. Further, the HRA FAQs indicate that the Departments intend to issue guidance providing that:

(a) for purposes of the annual dollar limit prohibition, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies provided under an employer payment plan, and, therefore, an HRA used to purchase coverage on the individual market under these arrangements will fail to comply with the annual dollar limit prohibition; and

(b) an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in the coverage, and any HRA that credits additional amounts to an individual, when the individual is not enrolled in primary coverage meeting the annual dollar limit prohibition provided by the employer, will fail to comply with the annual dollar limit prohibition.

The HRA FAQs also state that the Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing

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[6] See Affordable Care Act Implementation FAQs Part XI, available at http://www.dol.gov/ebsa/faqs/faq-aca11.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

3. Prior Guidance on the Application of the Market Reforms to Health FSAs

Under the interim final rules implementing the annual dollar limit prohibition, a health FSA, as defined in Code § 106(c)(2), is not subject to the annual dollar limit prohibition. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice limiting the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

4. Prior Guidance on the Application of Code §§ 36B and 5000A

Section 36B of the Code allows a premium tax credit to certain taxpayers who enroll (or whose family members enroll) in a qualified health plan (QHP) through an Affordable Insurance Exchange (referred to in this notice as an Exchange, and also referred to in other published guidance as a Marketplace). The credit subsidizes a portion of the premiums for the QHP. In general, the premium tax credit may not subsidize coverage for an individual who is eligible for other minimum essential coverage. If the minimum essential coverage is eligible employer-sponsored coverage, however, an individual is treated as eligible for that coverage only if the coverage is affordable and provides minimum value or if the individual enrolls in the coverage.

Coverage provided through Code § 125 plans, employer payment plans, health FSAs, and HRAs are eligible employer-sponsored plans and, therefore, are minimum essential coverage, unless the coverage consists solely of excepted benefits. See Code § 5000A(f)(2) and Treas. Reg. §1.5000A-2, 78 Fed. Reg. 53646, 53658 (August 30, 2013).

Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are counted for purposes of determining affordability of an eligible employer-sponsored plan under Code § 36B. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)). Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan are counted toward the plan's minimum value percentage for that plan year if the amounts may be used only to reduce cost-sharing for covered medical expenses and the amount counted for this purpose is the amount of expected spending for health care costs in a benefit year. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). See Q&A 11 of this notice for more explanation of the application of these rules to HRAs and other arrangements.

III. GUIDANCE

A. Guidance on HRAs and Certain other Employer Healthcare Arrangements, Health FSAs, and Employee Assistance Programs or EAPs Under the Joint Jurisdiction of the Departments

1. Application of the Market Reform Provisions to HRAs and Certain other Employer Healthcare Arrangements

Question 1: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May other types of group health plans used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the annual dollar limit prohibition?

Answer 1: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However the employer payment plan will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

Question 2: How do the preventive services requirements apply to an HRA that is integrated with a group health plan?

Answer 2: Similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements.

Question 3: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May a group health plan, including an HRA, used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the preventive services requirements?

Answer 3: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the preventive services requirements.

For example, a group health plan, such as an employer payment plan, that reimburses

employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the preventive services requirements because (1) an employer payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

Question 4: Under what circumstances will an HRA be integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements?

Answer 4: An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it meets the requirements under either of the integration methods described below. Pursuant to this notice, under both methods, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable.

Integration Method: Minimum Value Not Required

An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits; (2) the employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage); (3) the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse); (4) the HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits; and (5) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A (see Q&A 10 of this notice) and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

Integration Method: Minimum Value Required

Alternatively, an HRA that is not limited with respect to reimbursements as required under the integration method expressed above is integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services

requirements if (1) the employer offers a group health plan to the employee that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii); (2) the employee receiving the HRA is actually enrolled in a group health plan that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii), regardless of whether the employer sponsors the plan (non-HRA MV group coverage); (3) the HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and (4) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Example (Integration Method: Minimum Value Not Required)

Facts. Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of co-payments, co-insurance, deductibles, and premiums under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage. When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a co-payment, co-insurance, deductible, or premium under Employer B's non-HRA group coverage or medical care (as defined under Code § 213(d)) that is not an essential health benefit.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Example (Integration Method: Minimum Value Required)

Facts. Employer A sponsors a group health plan that provides minimum value and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon

termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides minimum value.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA MV group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Question 5: May an employee who is covered by both an HRA and a group health plan with which the HRA is integrated, and who then ceases to be covered under the group health plan that is integrated with the HRA, be permitted to use the amounts remaining in the HRA?

Answer 5: Whether or not an HRA is integrated with other group health plan coverage, unused amounts that were credited to an HRA while the HRA was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. Note that coverage provided through an HRA, other than coverage consisting solely of excepted benefits, is an eligible employer-sponsored plan and, therefore, minimum essential coverage under Code § 5000A.

Question 6: Does an HRA impose an annual limit in violation of the annual dollar limit prohibition if the group health plan with which an HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits (but limits the coverage to the HRA's maximum benefit)?

Answer 6: In general, an HRA integrated with a group health plan imposes an annual limit in violation of the annual dollar limit prohibition if the group health plan with which the HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit. This situation should not arise for a group health plan funded through non-grandfathered health insurance coverage in the small group market, as small group market plans must cover all categories of essential health benefits, with the exception of pediatric dental benefits, if pediatric dental benefits are available through a stand-alone dental plan offered in accordance with 45 C.F.R. §155.1065.[7]

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[7] Small group market plans will not be considered to fail to meet qualified health plan certification standards based solely on the fact that they exclude coverage of pediatric dental benefits that are otherwise required under ACA § 1302(b)(1)(J) where a stand-alone dental plan is also available. See

However, under the integration method available for plans that provide minimum value described under Q&A 4 of this notice, if a group health plan provides minimum value under Code § 36B(c)(2)(C)(ii), an HRA integrated with that group health plan will not be treated as imposing an annual limit in violation of the annual dollar limit prohibition, even if that group health plan does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit.

2. Application of the Market Reforms to Certain Health FSAs

Question 7: How do the market reforms apply to a health FSA that does not qualify as excepted benefits?

Answer 7: The market reforms do not apply to a group health plan in relation to its provision of benefits that are excepted benefits. Health FSAs are group health plans but will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).[8] See 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. § 146.145(c)(3)(v). Therefore, a health FSA that is considered to provide only excepted benefits is not subject to the market reforms.

If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements.[9]

The Departments understand that questions have arisen as to whether HRAs that are not integrated with a group health plan may be treated as a health FSA as defined in Code § 106(c)(2). Notice 2002-45, 2002-02 CB 93, states that, assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a health FSA as defined in Code § 106(c)(2). This statement was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs. The Departments are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition. In any event, the

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ACA § 1302(b)(4)(F) and Question 5, CMS QHP Dental Frequently Asked Questions, May 31, 2013, https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf.

[8] An HRA is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a Code § 125 plan. IRS Notice 2002-45, 2002-02 CB 93.

[9] Under the interim final rules implementing the annual dollar limit prohibition, a health FSA is not subject to the annual dollar limit prohibition, regardless of whether the health FSA is considered to provide only excepted benefits. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice regarding the restriction of the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

treatment of an HRA as a health FSA that is not excepted benefits would not exempt the HRA from compliance with the other market reforms, including the preventive services requirements, which the HRA would fail to meet because the HRA would not be integrated with a group health plan. This analysis applies even if an HRA reimburses only premiums.

Question 8: The interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs (as defined in Code § 106(c)(2)). See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). Does this exemption apply to a health FSA that is not offered through a Code § 125 plan?

Answer 8: No. The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code § 125 plan and thus subject to a separate annual limitation under Code § 125(i). There is no similar limitation on a health FSA that is not part of a Code § 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition.

To clarify this issue, the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 8 retroactively applicable as of September 13, 2013. As a result, a health FSA that is not offered through a Code § 125 plan is subject to the annual dollar limit prohibition and will fail to comply with the annual dollar limit prohibition.

3. Guidance on Employee Assistance Programs

Question 9: Are benefits under an employee assistance program or EAP considered to be excepted benefits?

Answer 9: The Departments intend to amend 26 C.F.R. §54.9831-1(c), 29 C.F.R. §2590.732(c), and 45 C.F.R. §146.145(c) to provide that benefits under an employee assistance program or EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Excepted benefits are not subject to the market reforms and are not minimum essential coverage under Code § 5000A. Until rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.

B. Guidance Under the Sole Jurisdiction of the Treasury Department and the IRS on HRAs and Code § 125 Plans

Question 10: Is an HRA that has fewer than two participants who are current employees on the first day of the plan year (for example, a retiree-only HRA) minimum essential coverage for purposes of Code §§ 5000A and 36B?

Answer 10: Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under standalone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the standalone HRA would constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore the coverage would constitute minimum essential coverage under Code § 5000A, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a standalone HRA for any month will not be eligible for a Code § 36B premium tax credit for that month. Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA.[10]

Question 11: How are amounts newly made available under an HRA treated for purposes of Code § 36B?

Answer 11: An individual is not eligible for individual coverage subsidized by the Code § 36B premium tax credit if the individual is eligible for employer-sponsored coverage that is affordable (premiums for self-only coverage do not exceed 9.5 percent of household income) and that provides minimum value (the plan's share of costs is at least 60 percent). If an employer offers an employee both a primary eligible employer-sponsored plan and an HRA that would be integrated with the primary plan if the employee enrolled in the plan, amounts newly made available for the current plan year under the HRA may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both. Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the minimum value requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations, to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013)

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[10] See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010).

(proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)).

Even if an HRA is integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition and the preventive services requirements (see Q&A 4 of this notice), the HRA does not count toward the affordability or minimum value requirement of the plan offered by the other employer. Additionally, if an employer offers an HRA on the condition that the employee does not enroll in non-HRA coverage offered by the employer and instead enrolls in non-HRA coverage from a different source, the HRA does not count in determining whether the employer's non-HRA coverage satisfies either the affordability or minimum value requirement.

For purposes of the Code § 36B premium tax credit, the requirements of affordability and minimum value do not apply if an employee enrolls in any employer-sponsored minimum essential coverage, including coverage provided through a Code § 125 plan, an employer payment plan, a health FSA, or an HRA, but only if the coverage offered does not consist solely of excepted benefits. See 26 C.F.R. §1.36B-2(c)(3)(vii). If an employee enrolls in any employer-sponsored minimum essential coverage, the employee is ineligible for individual coverage subsidized by the Code § 36B premium tax credit.

Question 12: Section 125(f)(3) of the Code, effective for taxable years beginning after December 31, 2013, provides that the term "qualified benefit" does not include any QHP (as defined in ACA § 1301(a)) offered through an Exchange.[11] This prohibits an employer from providing a QHP offered through an Exchange as a benefit under the employer's Code § 125 plan. Some states have already established Exchanges and employers in those states may have Code § 125 plan provisions that allow employees to enroll in health coverage through the Exchange as a benefit under a Code § 125 plan. If the employer's Code § 125 plan operates on a plan year other than a calendar year, may the employer continue to provide the Exchange coverage through a Code § 125 plan after December 31, 2013?

Answer 12: For Code § 125 plans that as of September 13, 2013 operate on a plan year other than a calendar year, the restriction under Code § 125(f)(3) will not apply before the first plan year of the Code § 125 plan that begins after December 31, 2013. Thus, for the remainder of a plan year beginning in 2013, a QHP provided through an Exchange as a benefit under a Code § 125 plan will not result in all benefits provided under the Code § 125 plan being taxable. However, individuals may not claim a Code § 36B premium tax credit for any month in which the individual was covered by a QHP provided through an Exchange as a benefit under a Code § 125 plan.

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[11] This rule does not apply with respect to any employee if the employee's employer is a qualified employer (as defined in ACA § 1312(f)(2)) offering the employee the opportunity to enroll through an Exchange in a qualified health plan in a group market. See Code § 125(f)(3)(B).

IV. APPLICABILITY DATE AND RELIANCE PERIOD

This notice applies for plan years beginning on and after January 1, 2014, but taxpayers may apply the guidance provided in this notice for all prior periods. If legislative action by any State, local, or Indian tribal government entity is necessary to modify the terms of a pre-existing HRA, a health FSA that does not qualify as excepted benefits, an employer payment plan, or other similar arrangement, sponsored by any State, local, or Indian tribal government entity, as an employer, to avoid a failure to comply with the market reforms (including action to terminate such arrangement) and such action may only be taken by a State, local, or Indian tribal government entity legislative body, the applicability date of the portions of this notice under which such arrangement would otherwise fail to comply with the market reforms is extended to the later of (1) January 1, 2014, or (2) the first day of the first plan year following the first close of a regular legislative session of the applicable legislative body after September 13, 2013.

V. FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this notice. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice. Questions concerning the information contained in this notice may be directed to the IRS at 202-927-9639, the DOL's Office of Health Plan Standards and Compliance Assistance at 202-693-8335, or HHS at 410-786-1565. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov, www.dol.gov/ebsa/healthreform, and at www.business.usa.gov.