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

ITEM
3.20
(ID # 7544)

MEETING DATE:
Tuesday, September 11, 2018

FROM : HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Voluntary Employees' Beneficiary Association Health Savings Plan Amended and Restated Plan Document, All Districts. [$0].

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify the attached amended and restated post-separation plan document for the Voluntary Employees' Beneficiary Association (VEBA) Full 213(d) Qualified Medical Care Expense Coverage Plan and authorize the Chairman of the Board to execute the plan document on behalf of the County. The official name of the plan is the County of Riverside, California Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan ("VEBA HSP" or "Plan"). This Plan document is amended and restated effective January 1, 2017.
2. Ratify the attached amended and restated post-separation plan document for the VEBA Limited HRA Plan and authorize the Chairman of the Board to execute the plan document on behalf of the County. The official name of the plan is the County of Riverside, California Voluntary Employees' Beneficiary Association Post-Employment Limited Health Savings Plan ("Limited HRA Plan" or "Plan"). This Plan document is amended and restated effective January 1, 2017.
3. Authorize the Chairperson to sign four (4) copies of each plan document; and
4. Direct the Clerk of the Board to retain one (1) copy of each signed plan document and return three (3) copies of each signed plan document to Human Resources for distribution.

ACTION: Policy

Brenda Diederichs
Brenda Diederichs, Assistant CEO / Human Resources Director 8/27/2018

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Jeffries, seconded by Supervisor Perez and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Washington, Perez and Ashley
Nays:	None
Absent:	Tavaglione
Date:	September 11, 2018
xc:	HR

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

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

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			**Budget Adjustment:** No **For Fiscal Year:** 17/18	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The 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.

Due to recent IRS regulation changes, updates are required to the VEBA HSP which took effect January 01, 2017. The following provisions summarize the VEBA HSP governing documents and recommended changes to incorporate compliance updates and other general housekeeping changes, while keeping the documents consistent with plan operations and best practices.

1. Allow participants to elect more flexible forms of limited HRA coverage to become eligible to make (or receive) contributions to a health savings account (HSA) or become eligible to claim the premium tax credit.
   - Limited HRA coverage is elective. New and expanded forms of Limited HRA Plan coverage have been designed to permit maximum benefits (coverage) allowed by law, which varies based on the participant's reason for the election.
   - Participants can now elect special forms of limited HRA coverage for specified covered individuals. Limited HRA coverage elections no longer have to apply uniformly to all of a participant's covered individuals.
   - The pre-Medicare limited-scope HRA coverage elections for premium tax credit eligibility purposes are no longer permanent until age 65 or Medicare eligibility. Limited-scope elections can now be "turned-off" when the participant is no longer receiving or claiming the premium tax credit for coverage purchased on the marketplace exchange.
   - Participants will automatically be covered under the Limited HRA Plan if they become re-employed by the County.
   - A new Limited HRA Coverage Election form will allow participants to indicate the reason for their election and list the covered individual(s) to whom their limited HRA coverage election should apply.
2. Expand coverage under the VEBA HSP Plan for participants who are re-employed by the County.

- This amendment is recommended by the Trust attorney and Plan consultant as a more favorable alternative to the participant's claims eligibility being fully suspended upon re-employment with the County.
- With the adoption of this change, participants under the post-separation HRA Plan will now be eligible for certain limited or "excepted" benefits during any period of re-employment with the County. Excepted benefits include expenses and premiums for dental, vision, and tax-qualified long-term care.
- Claims eligibility will no longer be fully suspended for previously separated participants who become re-employed.
- Importantly, post-separation HRA Plan participants can still be reimbursed for all types of qualified medical care expenses incurred after they separate from and are not re-employed with the contributing employer.

3. Incorporate other minor revisions to strengthen the current terms of the Plan and clarify aspects of plan operation.
   - In the event of divorce, participant accounts can now be split based upon a court order or divorce decree.
   - The Pre-Medicare Limited-Scope version of the Plan documents have been replaced with the new Limited HRA Plan document.
   - The Plan documents now require participants and the County to verify information submitted to or received from the Plan and to provide notice of financial errors within ninety (90) days from the date the errors were first reflected on an account statement or other Plan publication or communication of the information.
4. Include general housekeeping changes that are considered "best practice;" including the addition of certain definitions, as well as clarification around eligibility as a participant, claims eligibility, and funding or allocation of benefits.
   - 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.

Previous Agenda Reference: February 25, 2014; Agenda Number 3-18.

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: FULL 213(d) QUALIFIED MEDICAL CARE EXPENSE COVERAGE AMENDED AND RESTATED as of January 1, 2017

Attachment B: LIMITED HRA PLAN AMENDED AND RESTATED as of January 1, 2017

Lani Sioson, Principal Management Analyst 9/5/2018

Gregory P. Priamos, Director County Counsel 8/29/2018

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

(LIMITED HRA PLAN)

AMENDED AND RESTATED
As of January 1, 2017

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 Limited Health Savings Plan ("Limited HRA Plan" or "Plan"). The County may offer through the Trust one or more HRA plans or forms of HRA coverage from time to time. The terms "Plan" or "HRA Plan" shall refer to this Limited HRA Plan either individually or collectively with other HRA plans or forms of HRA coverage offered by the Trust, as the context indicates or requires. This Plan is offered by a Voluntary Employees' Beneficiary Association under Internal Revenue Code § 501(c)(9). This Plan document is amended and restated as of January 1, 2017 by the County of Riverside, California ("Employer") for the benefit of its eligible Participants.

1.2 Plan Documents. This Plan document sets for the terms and conditions for certain types of limited coverage under the Limited HRA Plan. This Plan document, together with the Trust instrument, any applicable collective bargaining agreements, and the individual Enrollment Form, shall constitute the Plan documents for Limited HRA Plan coverage. This Plan document amends, restates, and replaces the prior Pre-Medicare Limited Scope Plan document in its entirety.

1.3 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. This Plan coverage is intended for any Participant who is a former Employee of the Employer (or his or her Dependents according to the terms and conditions of the Plan and applicable law). Payment or reimbursement of Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or otherwise separated from service with the 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 Article V hereof and any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer. This Plan coverage is not integrated with a Group Health Plan but is exempt from certain provisions of PPACA known as the Mandates as a plan that covers less than two current-employees.

1.4 Limited HRA Coverage/Excepted Benefits Plan. Participants covered under this Limited HRA Plan may be subject to or may elect or may un-elect the specific Limited HRA Plan coverage offered under this Limited HRA Plan in accordance with the terms and conditions of the Plan, policies and procedures of the Administrator, and applicable law. The Plan may add additional types of Limited HRA Plan coverage or remove one or more types of Limited HRA

Plan coverage as permitted or required by applicable law or as determined by the Administrator in accordance with applicable law and the terms of the Plan Documents.

1.4.1 Limited-Scope/Excepted Benefits Coverage; Premium Tax Credit Eligibility. This Limited HRA Plan coverage is designed to be exempt from the Mandates as an HRA plan that provides only Excepted Benefits as further described under Section 5.1. This Limited HRA Plan coverage (i) does not qualify as "minimum essential coverage," as defined under IRC § 5000A, (ii) will not prevent a Participant from eligibility for an IRC § 36B premium tax credit, and (iii) will not be reported on IRS Form 1095B as required by IRC § 6055.

1.4.2 Coverage for Coordination of Benefits and Section 111 Reporting. This Limited HRA Plan coverage is designed to be exempt from the Mandates as an HRA plan that provides only Excepted Benefits as further described under Section 5.1. Excepted Benefits under this Limited HRA Plan coverage are further limited to only expenses and premiums for dental and vision in order to coordinate benefits for purposes of HRA coverage reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). This Limited HRA Plan coverage (i) does not qualify as "minimum essential coverage," as defined under IRC § 5000A, (ii) will not prevent a Participant from eligibility for an IRC § 36B premium tax credit, and (iii) will not be reported on IRS Form 1095B as required by IRC § 6055.

1.4.3 HSA Eligibility Coverage. Benefits under this Limited HRA Plan coverage may be expanded beyond Excepted Benefits only under certain circumstances set forth under Section 5.1 to allow a Participant to become eligible for contributions to a health savings account or HSA. Coverage for HSA eligibility purposes under this Limited HRA Plan (i) constitutes "minimum essential coverage," as defined under IRC § 5000A, (ii) will not be effective to enable a Participant to become potentially eligible for an IRC § 36B premium tax credit or for exemption from the Mandates, and (iii) will be reported on IRS Form 1095B as required by IRC § 6055.

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 Trust Agreement, second to the Plan Document, third to the applicable Employer Adoption Agreement, and fourth to the applicable Participant Enrollment Form.

1.6 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Expenses as described in Section 5.1, as such Benefits may be limited by elections of the Participant, the terms of the Plan, or applicable law.

"Claims-Eligible" with respect to a Participant means that such Participant has become eligible for reimbursement of Qualified Health Care Expenses under Article II 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 has not attained age 27) 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.

"Employee" means any individual that the Employer determines is a current or former employee of such 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.

"Excepted Benefits" means Qualified Health Care Expenses that would not be considered "minimum essential coverage" under IRC §5000A(f)(3). Excepted Benefits shall include benefits described under Treasury Reg. §54.9831-1(c)(3)(iii) and (iv), including expenses and premiums for coverage for any of the following, or as otherwise permitted by law:

(a) Medical care expenses substantially all of which are for the treatment of the eye or the mouth (including any organ or structure within the mouth); and

(b) Qualified long-term care services or medical care expenses incurred based on cognitive impairment or loss of functional capacity that is expected to be chronic, subject to indexed annual limits.

"Fiduciaries" The named fiduciaries under this Plan are the Trustee and the Employer, in its capacity as the plan sponsor and the Administrator. A Third-party Administrator may also be considered a fiduciary under applicable state or federal law to the extent the Third-party Administrator exercises discretion or takes other action deemed under applicable law to create a fiduciary status.

"Group Health Plan" or "GHP" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) and such term "group

health plan" is defined under IRC §§ 9032(a) and 5000(b)(1) and Treasury Regulation 54.9831-1(a)(1).

"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.

"Mandates" means provisions of PPACA known as the mandates and found under sections 2701-2719A of the Public Health Service Act ("PHSA"); Section 9815 of the Code (incorporating the PHSA provisions into the IRC); and Section 715 of ERISA (incorporating the PHSA provisions into ERISA.

"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.

"Qualified Health Care Expenses" means medical care expenses defined by IRC § 213(d) and IRC § 106(f) (for years to which IRC § 106(f) applies).

"Third-party Administrator" means one or more third parties appointed or contracted by the Employer from time to time to provide record-keeping, claims-payment, and/or other plan administration services to all or a portion of the Trust or this 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 (and the Dependents of such Participant become eligible for coverage) under this Limited HRA Plan on any date on or after the Participant Effective Date, that either (i) the Participant has for himself or herself or on behalf of his or her Dependents elected coverage under this Limited HRA Plan or (ii) the Participant or Dependent fails to meet the requirements for coverage and eligibility for Benefits under the Post-separation HRA Plan.

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.

Article III.
Funding or Allocation of Benefits

3.1 Contributions and Allocations of Assets. The Employer shall contribute or transfer assets to this Plan, or designate assets to be subject to the terms of this Plan, on behalf of its eligible Employees pursuant to collective bargaining agreements, other written agreements, policies, and/or the terms of this Limited HRA Plan or the Post-separation HRA Plan, as applicable. Employer contributions, transfers, or assets designated to be subject to the terms and conditions of this HRA Plan shall be specifically allocated to appropriate Participant Accounts for the purpose of providing for payment of the Benefits described hereinafter. The liabilities, expenses, costs and charges associated with each particular Participant Account shall be charged against the portion of assets of the Trust held with respect to that particular Participant Account.

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 two (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.

4.4 Splitting Participant Account Upon Court Order or Agreement. To the extent permitted and so long as it is not prohibited by applicable law, in the event of a Participant's divorce, a Participant Account may be split between the Participant and his or her former spouse upon receipt of a court order or agreement acceptable to the Administrator and subject to the policies and procedures of the Administrator; provided, however, the Administrator shall have the right not to split such account if it determines, in its sole discretion, that splitting of accounts upon divorce would result in disqualification of or adverse tax consequences for the Plan or Trust. The Administrator may value, report, withhold, and pay applicable taxes or other fees and charges in accordance with this Plan Document, the Administrator's policies and procedures, and applicable law.

4.5 Notify the Plan of Errors within Ninety (90) Days. Participants and the Employer should regularly review account information and immediately report any potential errors to the Administrator. If the Administrator (or a Third-party Administrator) does not receive notification of an account error within ninety (90) days from the date the potential account error is viewed by the applicable Participant or the Employer online through the Plan portal or first appears on an account statement or other report received by the applicable Participant or Employer, the Participant Account and/or Employer information will be considered correct. Notification of any potential errors should be in writing in accordance with Section 4.5.1 below.

4.5.1. Contents of Error Notification. Written notice of any potential account error must include: (1) the name of the Employer or Participant; (2) the applicable account number; and (3) a detailed description of the error, including any applicable dollar amounts and why the Participant or Employer believes it to be an error.

4.5.2 Investigation of Error. The Third-party Administrator will perform a timely investigation of any error notifications. The affected Participant(s) and/or the Employer will be notified regarding the results of the Plan's investigation and any corrective actions taken in accordance with the policies and procedures of the Administrator. Correction of any errors will be applied prospectively and, if timely and properly reported as required by this Section 4.5, retroactively to the date of the error.

4.6 Reliance Upon Data and Information from Participants and the Employer. It is the responsibility of Participants and the Employer in submitting data and information to the

Plan to ensure that such data and information is correct. The Administrator and its agents may rely upon any data or information submitted from a Participant or the Employer as true and correct. The Plan and its agents are not responsible for any errors made by a Participant or the Employer with regard to the data or information submitted to the Plan, nor are the Plan and its agents responsible for further errors that result from incorrect data or information submitted by a Participant or Employer. If a Participant or the Employer discovers that information or data submitted to the Plan was incorrect, it is the responsibility of that Participant or the Employer to timely notify the Plan in writing and correct the information or data.

Article V.
Qualified Health Care Expenses and Benefits under this Plan

5.1 Benefits for Qualified Health Care Expenses. Benefits under this Limited HRA Plan must be a payment or reimbursement for medical care expenses as defined by IRC §213(d) and excludable from income under IRC §105 and 106, as amended from time to time, subject to the limitations, terms, and conditions below and any other limitations, terms, and conditions under this Plan document, applicable law, or as otherwise provided in the policies and procedures of the Third-party Administrator. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under this Section, and Section 1.3. Benefits shall include Excepted Benefits expenses and premiums for qualified insurance coverage, reimbursed directly to the Participant.

5.1.1 General Limitations.

5.1.1.1 Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan. Benefits may not include reimbursement 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.

5.1.1.2 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 Benefits under this Plan.

5.1.1.3 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.

5.1.2 Specific Limited HRA Coverage Limitations. Participants covered under this Limited HRA Plan may be subject to or may elect or may un-elect any of the specific Limited HRA Plan Coverages offered under this Limited HRA Plan in accordance with the terms and conditions of the Plan, policies and procedures of the Administrator, and applicable law. The Plan may add additional types of Limited HRA coverage or remove one or more types of Limited HRA Plan coverage as permitted or required by applicable law or as determined by the Trustees in accordance with applicable law and the terms of the Plan Documents.

5.1.2.1 Limited-Scope/Excepted Benefits Coverage. Coverage for Participants and their Dependents under this Plan is based upon an election of Limited HRA Coverage in order for the Participant or a Dependent to become eligible for the premium tax credit under IRC §36B.

5.1.2.2 Coverage for Coordination of Benefits and Coverage to Prevent Section 111 Reporting. Participants or Dependents who are covered under this Limited HRA Plan shall be eligible for Excepted Benefits other than reimbursement for expenses and qualified premiums for long-term care if their coverage under this Plan is modified based upon an election of Limited HRA coverage in order to coordinate benefits for purposes of HRA coverage reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

5.1.2.3 Coverage for HSA Eligibility. Participants who are enrolled in or covered by a health savings account (HSA) may elect this Limited HRA Plan coverage in order to become eligible for contributions to an HSA. For Participants who elect this Limited HRA Plan coverage for HSA-eligibility purposes, Benefits under this Plan shall include only Excepted Benefits plus reimbursement for preventive care expenses and premiums for a high-deductible health plan under IRC § 223(c)(2)(A).

5.1.3 Claims for Benefits. Subject to the terms and conditions of this Plan, Participants may file claims for Qualified Health Care Expenses incurred on or after the date they become Claims-Eligible, provided that, before any claim may be submitted, 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 or Third-party Administrator to comply with applicable law, including without limitation, the reporting requirements under PPACA and 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.

5.1.4 Payment of Benefits. Payment of Benefits shall be made in accordance with the rules, regulations, and limitations established by the Third-party Administrator from time to time, consistent with the requirements of the Internal Revenue Code and any other applicable law.

5.1.5 Dependent Benefits in the Event of Death5.1.4 Dependent Benefits in the Event of Death. If Participant pass away, Participant's surviving spouse or estate representative can spend down your remaining account balance by filing claims for any unreimbursed medical care expenses Participant, Participant's spouse, and Participant's eligible dependents may have incurred prior to Participant's passing.

If Participant has a surviving spouse, remaining funds after all final claims have been reimbursed will be transferred to a new account for him or her. This new account can then be used to reimburse qualified medical care expenses incurred by Participant's surviving spouse and eligible dependents. Participant's surviving spouse can only add eligible dependents of the deceased participant to the account. Surviving spouses and eligible dependents enjoy the same tax advantages as participants.

If Participant's surviving spouse later passes away with funds remaining, the account would be transferred to Participant's surviving dependents provided that they are still a qualified dependent (Article I, Section 1.6), at the time of Participant's surviving spouse's passing. If there is more than one qualified dependent, the funds will be split equally among them. Should one of the dependents then pass away with a balance remaining, the funds would be reallocated equally among the other surviving dependents. When an account transfers to a surviving dependent and he or she loses dependent status, the surviving dependent may keep the account, but the HRA coverage becomes taxable at that time.

Remaining funds (if any) after all final claims have been reimbursed and no eligible survivors remain would 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. None of the Third-party Administrator, its agents, officers, or employees, nor the Trustee or other plan service provider shall be responsible for confirming or enforcing the terms of collective bargaining agreements, Employer policies, or other arrangements regarding the terms of an Employee's eligibility to participate under the Plan or amounts to be contributed on behalf of a Participant under the Plan. The Employer shall only be responsible for paying benefits up to the Participant's Participant Account balance or as agreed upon by the Employer in applicable employer policies or collective bargaining agreements.

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. Any potential errors

discovered regarding the investment elections or allocations of a Participant Account or Employer Account must be reported to the Plan in accordance with Section 4.6.

6.3 Reserved.

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;

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 6.6 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 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 Administrator 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: first to the Trust Agreement, second to the Plan Document, third to the applicable Employer Adoption Agreement, and fourth to the applicable Participant Enrollment Form.

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 SEP 11 2018.

COUNTY OF RIVERSIDE:

By: Brenda Diederichs
Brenda Diederichs
Asst. CEO / Human Resources

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: [signature]
Deputy

Date: SEP 11 2018

By: [signature]
Chairman, Board of Supervisors
CHUCK WASHINGTON

Date: SEP 11 2018

Approved as to form:

Gregory P. Priamos
County Counsel

By: [signature]
Deputy County Counsel
Michael Thomas

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: [signature]

Title: Senior Vice President

Address: P.O. Box 2127

Spokane, WA 99210-2127

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

FULL 213(d) QUALIFIED MEDICAL CARE EXPENSE COVERAGE

AMENDED AND RESTATED
As of January 1, 2017

Article I.
General Provisions

1.1 Name. The name of this Plan is the County of Riverside, California Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan ("Plan"). The Trust may offer one or more HRA plans or forms of HRA plan coverage from time to time. The terms "Plan" or "HRA Plan" shall refer to this Full 213(d) Qualified Medical Care Expense Coverage Plan either individually or collectively with other HRA plans or forms of HRA coverage offered by the Trust, as the context indicates or requires. This Plan is offered by a Voluntary Employees' Beneficiary Association under Internal Revenue Code § 501(c)(9). This Plan document is amended and restated as of January 1, 2017 by the County of Riverside, California ("Employer") for the benefit of its eligible Participants.

1.2 Plan Documents. This Plan document, together with the Trust instrument, any applicable collective bargaining agreements, and the individual Enrollment Form, shall constitute the Plan documents for the HRA plan coverage. This Plan document, the Trust, and the individual Enrollment Form shall constitute the Plan documents for the County of Riverside Plan for Full 213(d) Qualified Medical Care Expense Coverage. This Plan document is hereby amended and restated and replaces the prior Plan document in its entirety.

1.3 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. This Plan coverage is intended for any Participant who is a former Employee of the Employer (or his or her Dependents according to the terms and conditions of the Plan and applicable law). At the time a Participant separates from service from the Employer who has made or will continue to make contributions on behalf of the Participant, the Participant will be covered under this Plan. Payment or reimbursement of 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 Article V hereof and applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer. This Plan coverage is not integrated with a Group Health Plan, but is exempt from certain provisions of PPACA known as the Mandates as a plan the covers less than two current-employees.

1.4 Election to Forfeit Right to Benefits for Premium Tax Credit Eligibility. To the extent any Claims-Eligible Participant under this Plan 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 coverage from a marketplace exchange established in accordance with PPACA. In order to prevent the Participant Account from precluding eligibility for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Plan may, at any time, elect to waive and forfeit the right to Benefits for any Qualified Health Care Expenses incurred on and after the date of such election to and excluding the date on which such election is revoked by the Participant.

1.5 Election of Limited Coverage under the Limited HRA Plan. 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 Limited HRA Coverage, the terms and conditions of which are governed by the separate Limited HRA Plan document. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.5 shall be effective on and after the date of such election to and excluding the date on which such election is revoked by the Participant.

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 Trust Agreement, second to the Plan Document, third to the applicable Employer Adoption Agreement, and fourth to the applicable Participant Enrollment Form.

1.7 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Expenses as described in Section 5.1, as such Benefits may be limited by elections of the Participant, the terms of the Plan, or applicable law.

"Claims-Eligible" with respect to a Participant means that such Participant has satisfied the conditions required to become eligible for reimbursement of Qualified Health Care Expenses as described under Article II 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 has not attained age 27) 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.

"Employee" means any individual that the Employer determines is a current or former employee of such 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.

"Excepted Benefits" means Qualified Health Care Expenses that would not be considered "minimum essential coverage" under IRC §5000A(f)(3). Excepted Benefits shall include benefits described under Treasury Reg. §54.9831-1(c)(3)(iii) and (iv), including expenses and premiums for coverage for any of the following, or as otherwise permitted by law:

(a) Medical care expenses substantially all of which are for the treatment of the eye or the mouth (including any organ or structure within the mouth); and

(b) Qualified long-term care services or medical care expenses incurred based on cognitive impairment or loss of functional capacity that is expected to be chronic.

"Fiduciaries" The named fiduciaries under this Plan are the Trustee and the Employer, in its capacity as the plan sponsor and the Administrator. A Third-party Administrator may also be considered a fiduciary under applicable state or federal law to the extent the Third-party Administrator exercises discretion or takes other action deemed under applicable law to create a fiduciary status.

"Group Health Plan" or "GHP" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) and such term "group health plan" is defined under IRC §§ 9032(a) and 5000(b)(1) and Treasury Regulation 54.9831-1(a)(1).

"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 HRA Coverage" is coverage that limits Benefits for various purposes as required or permitted by applicable law, including, without limitation:

(i) Eligibility for contributions to a health savings account (HSA);

(ii) To coordinate benefits for purposes of HRA coverage reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA); and

(iii) To prevent preclusion of eligibility for an IRC § 36B premium tax credit during any month to purchase coverage from a marketplace exchange established in accordance with PPACA.

Limited HRA Coverage will be limited to Excepted Benefits only for purposes described in clause (iii), and in other cases required by law or to exempt Plan coverage from certain legal and regulatory mandates, including certain mandates under HIPAA, MMSEA, and/or PPACA. The terms and conditions for Limited HRA Coverage is governed by a separate Limited HRA Plan document.

"Mandates" means provisions of PPACA known as the mandates and found under sections 2701-2719A of the Public Health Service Act ("PHSA"); Section 9815 of the IRC (incorporating the PHSA provisions into the IRC); and Section 715 of ERISA (incorporating the PHSA provisions into ERISA.

"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.

"Qualified Health Care Expenses" means medical care expenses defined by IRC § 213(d) and IRC § 106(f) (for years to which IRC § 106(f) applies).

"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 one or more third parties appointed or contracted by the Administrator from time to time to provide record-keeping, claims-payment, and/or other plan administration services to 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 and Claims-Eligibility

2.1 Eligibility as a Participant. 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 is eligible to become a Participant (and the Dependents of such Participant become eligible for coverage) under this Post-separation Plan at the time of the first Employer deposit to this Plan on behalf of the Employee.

Except with respect to a surviving spouse who is also a Participant under the Plan, a surviving spouse of any deceased Participant is covered under this Plan as if such surviving spouse were a Participant who has separated from service from the applicable Employer; provided, however, that such surviving spouse shall not be subject to the rehire restriction limitations under Section 2.3 and shall not have the right to add Dependents.

2.2 Claims Eligibility. A Participant described in Section 2.1 becomes Claims-Eligible under this Plan, and becomes eligible for full Benefits under Article V, only upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions under Article V hereof, and any Employer policies and applicable collective bargaining agreements, or other Employer action or adoption procedure accepted by the Administrator.

2.3 Restriction on Claims-Eligibility. If, after Participant becomes Claims-Eligible under this Post-separation HRA Plan as described in Section 2.2, such Participant subsequently becomes Re-employed by the Employer, then during any period that the Participant Re-employed, the Participant shall not be covered or eligible for Benefits under this Post-separation HRA Plan, but shall be eligible for Excepted Benefits under the Limited HRA Plan according to the terms and conditions of the Limited HRA Plan document.

2.4 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.

2.5 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 or in accordance with the Administrator's policies and procedures, as applicable.

Article III.
Funding or Allocation of Benefits

3.1 Contributions and Allocation of Assets. The Employer shall contribute or transfer assets to this Plan, or designate assets to be subject to the terms of this Plan, on behalf of its Employees pursuant to collective bargaining agreements, other written agreements, policies, and/or the terms of this Post-separation Plan or the Limited HRA Plan, as applicable. Employer contributions, transfers, or assets designated to be subject to the terms and conditions of this HRA Plan shall be specifically allocated to appropriate Participant Accounts for the purpose of providing for payment of the Benefits described hereinafter. The liabilities, expenses, costs and charges associated with each particular Participant Account shall be charged against the portion of assets of the Trust held with respect to that particular Participant Account.

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 two (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.

4.4 Splitting Participant Account Upon Court Order or Agreement. To the extent permitted and so long as it is not prohibited by applicable law, in the event of a Participant's divorce, a Participant Account may be split between the Participant and his or her former spouse upon receipt of a court order or agreement acceptable to the Administrator and subject to the policies and procedures of the Administrator; provided, however, the Administrator shall have the right not to split such account if it determines, in its sole discretion, that splitting of accounts upon divorce would result in disqualification of or adverse tax consequences for the Plan or Trust. The Administrator may value, report, withhold, and pay applicable taxes or other fees and charges in

accordance with this Plan Document, the Administrator's policies and procedures, and applicable law.

4.5 Notify the Plan of Errors within Ninety (90) Days. Participants and the Employer should regularly review account information and immediately report any potential errors to the Administrator. If the Administrator (or a Third-party Administrator) does not receive notification of an account error within ninety (90) days from the date the potential account error (a) is viewed by the applicable Participant or the Employer online through the Plan portal or (b) first appears on an account statement or other report received by the applicable Participant or Employer, the Participant Account and/or Employer information will be considered correct. Notification of any potential errors should be in writing in accordance with Section 4.5.1 below.

4.5.1. Contents of Error Notification. Written notice of any potential account error must include: (1) the name of the Employer or Participant; (2) the applicable account number; and (3) a detailed description of the error, including any applicable dollar amounts and why the Participant or Employer believes it to be an error.

4.5.2 Investigation of Error. The Third-party Administrator will perform a timely investigation of any error notifications. The affected Participant(s) and/or the Employer will be notified regarding the results of the Plan's investigation and any corrective actions taken in accordance with the policies and procedures of the Administrator. Correction of any errors will be applied prospectively and, if timely and properly reported as required by this Section 4.5, retroactively to the date of the error.

4.6 Reliance Upon Data and Information from Participants and the Employer. It is the responsibility of Participants and the Employer in submitting data and information to the Plan to ensure that such data and information is correct. The Plan and its agents may rely upon any data or information submitted from a Participant or Employer as true and correct. The Plan and its agents are not responsible for any errors made by a Participant or Employer with regard to the data or information submitted to the Plan, nor are the Plan and its agents responsible for further errors that result from incorrect data or information submitted by a Participant or Employer. If a Participant or Employer discovers that information or data submitted to the Plan was incorrect, it is the responsibility of that Participant or Employer to timely notify the Plan in writing about the error and correct the incorrect information or data.

Article V.
Qualified Health Care Expenses and Benefits under this Plan

5.1 Benefits for Qualified Health Care Expenses. Benefits under this Plan must be a payment or reimbursement for medical care expenses as defined by IRC §213(d) and excludable from income under IRC §105 and 106, as amended from time to time, subject to the limitations, terms, and conditions below and any other limitations, terms, and conditions under this Plan document, applicable law, or as otherwise provided in the policies and procedures of the Third-party Administrator. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under this Section, and Section 1.3. Benefits

shall include Excepted Benefits expenses and premiums for qualified insurance coverage, reimbursed directly to the Participant.

5.1.1 General Limitations.

5.1.1.1 Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan. Benefits may not include reimbursement 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.

5.1.1.2 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 Benefits under this Plan.

5.1.1.3 Limited HRA Coverage is available to Participants or Dependents who desire to limit their Benefits to coordinate with other benefit plans or limitations or other benefits allowed under applicable law. Limited HRA Coverage shall be subject to the terms and conditions of the Limited HRA Plan document, limitations and provisions of applicable law, and rules, regulations and limitations established by the Administrator from time to time.

5.1.1.4 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.

5.1.2 Claims for Benefits. Subject to the terms and conditions of this Post-separation HRA Plan, Participants may file claims for Qualified Health Care Expenses incurred on or after the date they become Claims-Eligible, provided that, before any claim may be submitted, 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 or Third-party Administrator to comply with applicable law, including without limitation, the reporting requirements under PPACA and 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.

5.1.3 Payment of Benefits. Payment of Benefits shall be made in accordance with the policies and procedures and other rules, regulations and limitations established by the Third-party Administrator from time to time consistent with the requirements of the Internal Revenue Code and any other applicable law.

5.1.4 Dependent Benefits in the Event of Death. If the Participant passes away, the Participant's surviving spouse or estate representative can spend down your remaining account balance by filing claims for any unreimbursed medical care expenses the

Participant, Participant's spouse, and Participant's eligible dependents may have incurred prior to Participant's passing.

If Participant has a surviving spouse, remaining funds after all final claims have been reimbursed will be transferred to a new account for him or her. This new account can then be used to reimburse qualified medical care expenses incurred by Participant's surviving spouse and eligible dependents. Participant's surviving spouse can only add eligible dependents of the deceased participant to the account. Surviving spouses and eligible dependents enjoy the same tax advantages as participants.

If Participant's surviving spouse later passes away with funds remaining, the account would be transferred to Participant's surviving dependents provided that they are still a qualified dependent (Article I, Section 1.6), at the time of Participant's surviving spouse's passing. If there is more than one qualified dependent, the funds will be split equally among them. Should one of the dependents then pass away with a balance remaining, the funds would be reallocated equally among the other surviving dependents. When an account transfers to a surviving dependent and he or she loses dependent status, the surviving dependent may keep the account, but the HRA coverage becomes taxable at that time.

Remaining funds (if any) after all final claims have been reimbursed and no eligible survivors remain would 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 2.5.

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. None of the Third-party Administrator, its agents, officers, or employees, nor the Trustee or other plan service provider shall be responsible for confirming or enforcing the terms of collective bargaining agreements, Employer policies, or other agreements regarding the terms of an Employee's eligibility to participate under the Plan or amounts to be contributed on behalf of a Participant under the Plan. The Employer shall only be responsible for paying benefits up to the Participant's Participant Account balance or as agreed upon by the Employer in applicable employer policies or collective bargaining agreements.

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. Any potential errors discovered regarding the investment elections or allocations of a Participant Account or Employer Account must be reported to the Plan in accordance with Section 4.5.

6.3 Reserved.

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;

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 6.6 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 Employer's 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. In its capacity as the Administrator, 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 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 Administrator including the following: income statement, balance sheet, number of Participant Accounts, and other such reports which are permitted by law, or as the Administrator and/or Employer requests and agreed to by the Third-party Administrator.

7.3 Consultants, Investment Managers, Third-party Administrators, Lawyers & Accountants. The Administrator 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 Administrator 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 Administrator 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 Administrator 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: first to the Trust Agreement, second to the Plan Document, third to the applicable Employer Adoption Agreement, and fourth to the applicable Participant Enrollment Form.

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 SEP 11 2018.

COUNTY OF RIVERSIDE:

By: _____
Brenda Diederichs
Asst. CEO / Human Resources

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: SEP 11 2018

By: _____
Chairman, Board of Supervisors
CHUCK WASHINGTON

Date: SEP 11 2018

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel
Michael Thomas

Approved as to form and content:

BY: WASHINGTON TRUST BANK,
a Washington corporation

By: _____

Title: Senior Vice President

Address: P.O. Box 2127

Spokane, WA 99210-2127